10. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

A. Member Grievance Resolution Process

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP has established and maintains written procedures for the submittal, processing, and resolution of all Member grievances and complaints.[1,2,3,4]

B. A Member has the right to file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction.[5,6,7]

PURPOSE:

A. To establish and maintain a timely and responsive procedure for submittal, process and resolution of all Member grievances and complaints.

B. To identify and correct negative trends and potential problems regarding access to care, quality of care, denial of service, continuity of care, staff, confidentiality, or Provider network issues for quality improvement.

DEFINITIONS:

A. **Standard Grievance** - An oral or written expression of dissatisfaction regarding any matter other than an Adverse Benefit Determination/Notice of Action (NOA). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, and the Member's right to dispute an extension of time proposed by IEHP to make an authorization decision.[8,9,10,11] Grievances include, but are not limited to, complaints about waiting times for appointments, disputes, timely assignment to a Provider, issues related to cultural or linguistic access or sensitivity, difficulty accessing specialists or other services, delays and denials of care, requests for treatment, administration and delivery of medical benefits, continuity of care, staff, facility, or other medical care problems, and concerns regarding Member confidentiality in the Provider network and/or at IEHP made by a Member or the Member's representative. A complaint is the same as a Grievance.[12] The term

[1] Title 22, California Code of Regulations (CCR) § 53858(a)
[2] 22 CCR § 53260
[3] 28 CCR § 1300.68(a)
[4] California Health and Safety Code (Health & Saf. Code) § 1368(a)(1)
[5] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.65
[6] Ibid.
[7] Title 42 Code of Federal Regulation (CFR) § 438.402(c)(2)(i)
[8] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.65
[9] Ibid.
[10] 28 CCR § 1300.68(a)(1)
[11] 42 CFR § 438.400(b)
[12] 28 CCR § 1300.68(a)(2)

"grievance" need not be used for a complaint to be captured as an expression of dissatisfaction and processed as a grievance.[13] If IEHP is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.[14]

Grievances that involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit, are treated as appeals.[15]

B. **Expedited Grievance** – A type of grievance that IEHP considers to be urgent if the Member's medical condition involves an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.[16,17,18]

C. **Exempt Grievance** - A type of grievance received by telephone, which are not coverage disputes or disputed health services involving medical necessity, experimental and/or investigational treatments or related to quality of care, and that are resolved by the close of the next business day. Exempt Grievances are exempt from the requirement to send written acknowledgment and response to Members,[19,20,21] and are incorporated into the quarterly grievance and appeal report that is submitted to DHCS.

D. **Inquiry** - A request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other IEHP processes. If the Member expressly declines to file a grievance, the complaint is still categorized as a grievance and not an inquiry. [22]

E. **Quality of Care (QOC) Grievance** – A grievance category, wherein actions taken or not taken by the Member's Provider could result in potential harm to the Member or an adverse event that impacts the health of the patient.

F. **Grievance Resolution –** For the purpose of this policy, a resolved grievance means that a final conclusion has been reached with respect to the Member's submitted grievance.[23]

G. **Potential Quality Incident (PQI)** - IEHP's Quality Management Department defines and establishes a process to review, monitor and report all PQIs.

[13] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[14] 28 CCR § 1300.68(a)(1)
[15] 28 CCR § 1300.68(d)(4)-(5)
[16] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.65
[17] CA Health & Saf. Code 1368.01(b)
[18] 22 CCR § 53858(e)(7)
[19] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.65
[20] CA Health & Saf. Code § 1368(a)(4)(B)(i)
[21] 28 CCR § 1300.68(d)(8)
[22] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[23] 28 CCR § 1300.68(a)(4)

H. **Authorized Representative** – This may include a relative, a representative, a Provider, or attorney, who may represent a Member during the grievance process.

I. **Delegate** – For the purpose of this policy, this is defined as a medical group, Health Plan, IPA, or any contracted organization delegated to provide services to IEHP Members.

PROCEDURES:

Member Rights and Options

A. The Member, a Provider acting on behalf of the Member, or the Member's authorized representative has the right to file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction via the following options:[24]

1. By phone toll free at (800) 440-IEHP (4347) or (800) 718-4347 (TTY);[25,26]
2. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;
3. In person at 10801 Sixth St., Suite 120, Rancho Cucamonga, CA 91730-5987;
4. Via facsimile at (909) 890-5748;
5. Online through the IEHP website at www.iehp.org;
6. A complaint form obtained at an IPA, Hospital or Provider's (Primary Care, Specialty Care or Vision) office with their assistance.[27,28]

(See "Attachment/Member Complaint Form – IEHP Covered" [29] in threshold languages in IEHP Portal).

B. Members that are minors, incompetent or incapacitated, may have a grievance filed on their behalf by the parent, guardian, conservator, relative, or other representative of the Member, as appropriate.[30]

C. Members are given reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person as well as in writing, in support of their grievance.[31,32,33]

D. Members have the right to request translation services to file their grievance in their preferred

[24] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[25] 28 CCR § 1300.68(b)(4)
[26] 22 CCR § 53858(b)
[27] 28 CCR § 1300.68(b)(7)
[28] 22 CCR § 53858(f)
[29] https://www.iehp.org/en/providers/provider-resources?target=forms
[30] CA Health & Saf. Code § 1368(b)(2)
[31] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2, Covered California Enrollee Appeals and Grievances
[32] Ibid.
[33] 42 CFR § 438.406(b)(4)

language or format.[34,35]

E. Members have the right to file a grievance if their cultural or linguistic needs are not met.

F. Members have the right to obtain access to and copies of relevant grievance and appeal documents upon request by contacting Member Services.

G. Members contacting IEHP to file a grievance regarding dental services are referred to Denti-Cal, the State Dental Program dependent upon State dental benefit coverage.

J. Members and potential Members have the right to file a discrimination grievance with IEHP before filing with the Office of Civil Rights (OCR) or the United States Department of Health and Human Services Office of Civil Rights.[36]

1. Grievances alleging discrimination must be submitted to IEHP's Section 1557 Coordinator for review within 180 calendar days of the date the person filing the grievance becomes aware of the alleged discriminatory action. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

2. All cases alleging discrimination against Members or eligible beneficiaries are forwarded to DHCS OCR for review within ten (10) days of mailing a discrimination grievance resolution letter. Please see Policy 9H3, "Cultural and Linguistic Services – Non-Discrimination."

K. Members with complaints regarding confidentiality, have the right to file a grievance to any of the following:

1. IEHP Compliance Officer:

   a. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;

   b. By telephone at (866) 355-9038;

   c. By fax at (909) 477-8536; or

   d. By e-mail at Compliance@iehp.org; or

2. The California Department of Health Care Services Privacy Officer:

   a. By mail at: DHCS Privacy Officer, P.O. Box 997413 MS0010, Sacramento, CA 95899-7413;

   b. By telephone at (916) 445-4646 or (866) 866-0602 TTY/TDD; or

   c. By email at PrivacyOfficer@dhcs.ca.gov; or

3. The Department of Health and Human Services Office of Civil Rights:

   a. By mail at: Attention: Regional Manager, 90 7th Street, Suite 4-100, San Francisco,

[34] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04
[35] Ibid.
[36] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.043

CA 94103;

b. By phone at (800) 368-1019 or (800) 537-7697 TDD; or

c. By email at ocrmail@hhs.gov.

L. All IEHP staff and external IEHP committee members are required to sign a confidentiality statement agreeing not to disclose confidential information. However, IEHP may use or disclose a Member's individually identifiable health information without a Member's authorization as follows:

1. For the direct provision of care or treatment of the patient;
2. For payment transactions, including billing for Member care;
3. For IEHP operational activities, including quality review;
4. If the request originates with a healthcare Provider who is involved in the treatment of the Member such as a pharmacy or a laboratory;
5. If the request is made to provide care to an inmate of a correctional facility; or
6. If the request is made by a representative of an accredited body.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, and annually thereafter and upon request. [37,38,39,40,41] Please see Policy 10B, "Member Appeal Resolution Process," for information on the Member appeal resolution process.

B. IEHP does not discriminate on the basis of race, color, national origin, sex, age, mental or physical disability or medical condition, ethnicity, ethnic group identification, ancestry, language, religion, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment.[42,43,44,45,]

C. IEHP has adopted an internal grievance procedure that provides for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services Section 1557. IEHP has designated a Grievance and Appeals

[37] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.9, Covered California Enrollee Materials: Basic Requirements
[38] Ibid.
[39] CA Health & Saf. Code § 1368(a)(2)
[40] 28 CCR § 1300.68(b)(2)
[41] 22 CCR § 53858(a)(2)
[42] 42 CFR § 422.110(a)
[43] 45 CFR Part 92
[44] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91
[45] CA Government Code (Gov. Code) § 11135(a)

Manager as its Section 1557 Coordinator, who is responsible for ensuring compliance with federal and state non-discrimination requirements and investigating discrimination grievances. [46] Any person who believes someone has been subjected to discrimination on the basis of race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment, may file a grievance under this procedure. It is against the law for IEHP to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.[47]

D. IEHP neither discourages the filing of grievance nor discriminates against any Member for filing a grievance or appeal.[48]

E. IEHP ensures that Members with linguistic and cultural needs as well as Members with disabilities have access to and can fully participate in IEHP's grievance process by assisting those with limited English proficiency or with a visual or other communicative impairment.[49,50,51, 52]

F. IEHP provides reasonable assistance throughout the grievance and appeals process, which includes but is not limited to, providing and completing the forms, navigating the health plan's website, providing communication in threshold languages or in alternative format or languages upon request by the Member or Member's authorized representative, and access to interpreters for other languages, face-to-face, and/or telephonic translators.[53,54] IEHP staff may use the California Relay Services if necessary or requested by a Member with a hearing or speech disability.

G. IEHP provides a Telephone Typewrite (TTY) line (800) 718-4347 for Members with hearing or speech impairments. IEHP Member Services Representatives (MSRs) may use the California Relay Services, if necessary or requested by the Member. Bilingual MSRs and Grievance Coordinators are proficient in Spanish to assist Spanish-speaking Members. Access to interpreters for other languages is obtained through IEHP's contracted interpretation services. If necessary, IEHP Grievance staff may request IEHP Member Services to arrange for face-to-face or telephonic translations, and sign language services for medical appointments.

[46] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 1, Section 1.13 Other Laws
[47] Title 42 United States Code (USC) § 18116
[48] 28 CCR § 1300.68(b)(8)
[49] CA Welfare and Institutions Code (Welf. & Inst. Code) § 1367.04
[50] 22 CCR § 53858(e)(6)
[51] 28 CCR § 1300.68(b)(3)
[52] 45 CFR § 92.101
[53] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04
[54] Californ Ibid.

H. The Compliance Officer for IEHP has the primary responsibility for oversight and direction of policies and procedures related to confidentiality and/or Health Insurance Portability and Accountability Act (HIPAA) violations. The Compliance Officer or their delegate is actively involved in the investigation and resolution of grievances related to confidentiality and/or HIPAA violations.

1. All Members are informed of the Notice of Privacy Practices (NPP) upon enrollment. In addition, the NPP is made available in writing to Members upon request, is available online through the IEHP web site, and is posted in common, public areas.

H. IEHP encourages Members to discuss any issues with their Provider to promote open communication and improve long-term Member and Provider relationships. If they are unable to resolve the issue, the Provider will assist the Member with contacting IEHP to initiate the grievance process.

I. IEHP does not reveal Provider or Member identity or personal information to any source other than for purposes of treatment, payment or IEHP operations, without the express written authorization of the Member or the Member's representative.[55]

J. IEHP shall continue to provide previously authorized services to the Member while the grievance is being resolved.

K. IEHP ensures that only authorized representatives file cases on behalf of the Member, by determining that an individual filing on behalf of a Member is authorized to do so by the State.

L. IEHP ensures that the person making the final decision for the proposed resolution of grievances and appeals has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in a prior decision. Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease make the final determination for all clinical grievances, including those regarding denial of a request for expedited resolution of an appeal.[56,57,58]

M. Fiscal and administrative concerns shall not influence the independence of the medical decision- making process to resolve any medical dispute between Member and Provider of service.[59]

N. IEHP maintains all Member grievances, including medical records, documents, evidence of coverage or other information relevant to the grievance decision in confidential electronic case files for ten (10) years.[60]

Provider Responsibilities

A. All Providers (e.g., Primary Care, Specialty Care and Vision) are required to have IEHP

[55] 45 CFR § 164.502(a)(1)(ii)
[56] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution
[57] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.70.4
[58] 42 CFR § 438.406(b)(2)
[59] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367
[60] California Welfare and Institutions Code (Welf. & Inst. Code), § 1009

Member Complaint Forms and copies of the IEHP Grievance Resolution Process readily available for Members who wish to file a grievance (See "Attachment/Member Complaint Form – IEHP Covered" in threshold languages, "Grievance Resolution Process — IEHP Covered English," and "Grievance Resolution Process –IEHP Covered – Spanish" [61]in IEHP Portal).[62,63]

B. Providers who receive an IEHP Member Complaint Form and/or documentation regarding a grievance must immediately fax them to IEHP's Grievance and Appeals Department at (909) 890-5748 (See "Attachment/Member Complaint Form –IEHP Covered in threshold languages" [64] in IEHP Portal).

C. Any Provider contacted by a Member who wants to file a grievance must immediately assist the Member by contacting IEHP's Member Services Department at (800) 440-IEHP (4347) or (800) 718-4347 (TTY).

D. Providers and Delegates, who are party to a grievance must respond to requests received from IEHP as expeditiously as possible but not to exceed the specified due date. Failure to do so may result in disciplinary action up to and including termination of contract.

E. Providers and their staff must cooperate with IEHP in resolving Member grievances and comply with all final determinations of IEHP's grievance process.

F. Providers must ensure a Member's medical condition is at no time permitted to deteriorate because of delay in provision of care that a Provider disputes.

Member Grievance Notification Requirements

A. IEHP utilizes DHCS-approved templates when informing Members of a Grievance or Appeal resolution. All templates include the DHCS-approved "Your Rights" attachment, language assistance taglines and Non-Discrimination Notice. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.

B. All Member grievance correspondence, Member Complaint Forms, and the IEHP Grievance Resolution Process handouts meet all language and accessibility standards. This includes fully translating the correspondence in the Member's required language.[65]

C. For partially translated grievance correspondence mailed during the implementation period, IEHP is required to meet the requirements, including but not limited to inserting a sentence that informs the Member, in their required language, how to obtain oral interpretation of the clinical rationale on an expedited basis, as well as, mailing a fully translated correspondence,

[61] https://www.iehp.org/en/providers/provider-resources?target=forms
[62] 28 CCR § 1300.68(b)(7)
[63] 22 CCR § 53858(f)
[64] https://www.iehp.org/en/providers/provider-resources?target=forms
[65] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04

with a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent.[66]

D. All grievances are responded to either verbally or in writing, including quality of care cases. Exempt grievances are exempt from the requirement to respond in writing.

Grievance Resolution Process

A. IEHP's Grievance and Appeals Department is responsible for the resolution of Member complaints, including grievances and appeals. Grievance records include the following information:[67,68,69]

1. Dates of receipt and closure by IEHP;
2. Member's name and identification number;
3. IEHP staff person responsible for the case;
4. A description of the grievance;
5. A description of the action taken to investigate and resolve the grievance;
6. A description of the resolution;
7. Date of resolution notice; and
8. Copies of relevant information used in the case.

B. IEHP ensures grievances are resolved as quickly as the Member's health condition requires and not to exceed these regulatory timeframes:[70]

1. Standard grievances are resolved within 30 calendar days of receiving the grievance.[71,72,73,74,75] In the event a resolution is not reached within 30 calendar days of receiving the grievance, the Member is notified in writing of the status of the grievance and the estimated date of resolution.[76,77] All cases are resolved based on clinical urgency of the Member's condition.
2. Expedited grievances are resolved no later than 72 hours from the receipt date and

[66] Ibid.
[67] Ibid.
[68] 28 CCR § 1300.68(b)(5)
[69] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[70] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution
[71] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.65
[72] Ibid.
[73] CA Health & Saf. Code § 1368.01(a)
[74] 22 CCR § 53858(g)(1)
[75] 28 CCR § 1300.68(d)(3)
[76] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[77] 22 CCR §53858(g)(2)

time.[78,79]

C. An acknowledgment letter is provided to the Member that is dated and postmarked within five (5) calendar days of receipt of the standard grievance, which includes:[80,81,82]

1. The grievance receipt date;
2. Name of the IEHP representative who may be contacted regarding the grievance;
3. The toll-free telephone number, and address of the IEHP representative who may be contacted about the grievance;
4. How to initiate the complaint process through the Department of Managed Health Care (DMHC), as applicable; and
5. The Member's right to appoint a representative to act on his/her behalf during the grievance process. [83]

D. Expedited grievance cases do not require Acknowledgement Letters, as the Resolution Letter is mailed within 72 hours.[84] Oral notice of resolution of an expedited grievance is provided within 72 hours.[85,86]

1. Within twenty-four (24) hours of receiving the grievance, IEHP notifies the Member whether or not the grievance met the criteria for expedited review, as defined in this policy. If criteria are met, the Member is informed of the shortened timeframe to submit information related to their case, and of their right to notify DMHC of their grievance.
2. If the grievance does not meet the criteria for expedited review, IEHP informs the Member by mail within three (3) calendar days of receiving their grievance that this will be processed as a standard grievance.

E. IEHP makes good faith efforts to obtain input from a party involved in the grievance, when this is necessary to resolve the Member's complaint. Parties to a grievance may include but are not limited to Providers, Delegates, and Hospitals; hereinafter referred to as "Respondent." When necessary, IEHP faxes or emails a Grievance Summary Form (GSF) or request for medical records to the Respondent, containing the substance of the grievance, identified issues to be addressed by the Respondent, and a request for pertinent documents (i.e., medical records, call notes, policies) that may aid in the investigation.

1. Responses are due to IEHP by the due date specified on the GSF or medical record request. For expedited grievances, the due date may be in less than 24 hours from the time

[78] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68.01
[79] 42 CFR § 438.408(b)(3)
[80] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.43.3
[81] CA Health & Saf. Code § 1368(a)(4)(A)
[82] 28 CCR § 1300.68(d)(1)
[83] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.71.38
[84] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68.01
[85] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68.01
[86] Ibid.

the GSF or medical record request is sent to the Respondent.

2. Respondents must procure and assemble all requested information upon receipt of the GSF or medical record request.
3. Once a response is received, IEHP reviews the information to ensure all Member issues were addressed. If Member issues are not completely addressed, IEHP notifies the Respondent that additional information is needed.
4. IEHP makes good faith efforts to obtain a complete and timely response to the GSF or medical record request:
    a. If not received by the due date, IEHP will follow-up with the Respondent telephonically and in writing.
    b. If IEHP remains unsuccessful in obtaining a response, the grievance is resolved to address the Member's needs based on the available information.
    c. Continued failure to respond timely to grievance requests may result in a Corrective Action Plan (CAP), freezing new Member assignments, or further disciplinary action up to and including termination of contract.

F. IEHP takes into account all comments, documents, records, and other information submitted by the Member or their representative, without regard to whether such information was submitted or considered in the initial action.[87, 88]

G. A Member may request to withdraw a grievance in writing at any time before IEHP mails a resolution letter. If the Member withdraws a quality of care grievance, IEHP will continue to its investigation but is not required to notify the Member of the outcome.

H. Once the grievance is resolved, IEHP mails the Member a resolution letter within 30 calendar days of receipt of a standard grievance and within 72 hours of receipt of an expedited grievance.[89,90] Resolution letters shall contain a clear and concise explanation of IEHP's decision.[91,92,93] In the case of expedited grievances, a copy of the resolution letter is also sent to DMHC. Providers may obtain a copy of the resolution, upon request.

I. Grievances involving quality of care issues may be reported to IEHP's Quality Management Team upon resolution of the case. IEHP's Medical Director is notified immediately upon

[87] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution
[88] 42 CFR § 438.406(b)(2)(iii)
[89] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68.01
[90] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[91] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.01
[92] CA Health & Saf. Code § 1368(a)(5)
[93] 28 CCR § 1300.68(d)(3)

receipt of a potential quality of care case.[94,95,96]

J. After case review, the IEHP Grievance & Appeals staff determines and assigns a level to the case as follows:

1. Level 0 – No substantiated issue identified.
2. Level 1 – Provider non-response to GSF. Unable to determine if Member grievance was substantiated due to lack of information, documentation and/or evidence.
3. Level 2 – Substantiated grievance with information, documentation, and/or evidence that has not resulted in any harm to the Member.
4. Level 3 – Substantiated grievance with information, documentation, and/or evidence that has resulted in some harm to the Member.
5. Level 4 – Substantiated grievance with information, documentation, and/or evidence that has resulted in significant harm to the Member.

Monitoring and Oversight

A. The Director of Grievance and Appeals is the designated Officer of the plan who has the primary responsibility for the maintenance of the IEHP Grievance Resolution System.[97]

B. Review and analysis of recorded grievances and appeals related to access to care, quality of care and denial of services, is presented to the Quality Management Committee on at least a quarterly basis. IEHP takes appropriate action to remedy any problems identified.[98]

C. Grievances related to Provider's office site quality issues are referred to Quality Management for assessment of physical accessibility, physical appearance, adequacy of waiting room and examination room space, appointment availability, and adequacy of treatment record-keeping.

D. Substantiated QOC grievances may result in the issuance of a CAP or education at the direction of the IEHP Medical Director.

E. IEHP monitors the rate of overall grievance response timeliness and reports findings to the Delegation Oversight Committee.

1. The rate of grievance response timeliness is reported to Delegates monthly. Timeliness rates are based on the initial expected response due date and date a complete response is received, addressing all alleged issues.
2. IEHP issues a CAP for Delegates that do not meet grievance response timeliness for two (2) consecutive months.
3. The grievance response timeliness rate and number of CAPs issued for the year are used

[94] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68 Grievance System
[95] Ibid.
[96] 22 CCR § 53858(e)(2)
[97] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 5, Section 5.2.4, Quality Improvement Plans
[98] 22 CCR § 53858(e)(3) and (4)

to score Providers annually on the Provider Evaluation Tool (PET).

F. Respondents who meet established thresholds for non-response are referred to the Provider Relations Department for follow-up and potential escalation, including issuance of Corrective Action Plan (CAP), freezing new Member assignments, or further disciplinary action up to and including termination of contract.

1. Respondents that are issued a CAP must submit by the specified due date a completed CAP.
2. IEHP will review the CAP to ensure that all findings are addressed, and all pertinent information is included. IEHP will either deny or approve the CAP.
3. Respondents that do not submit a complete CAP by the specified due date are escalated up to the Director of Provider Relations.
4. The Director of Provider Relations will outreach to the Respondent regarding their CAP, and determine further disciplinary action, which may include freezing new Member assignments until a complete CAP is submitted.
5. Continued non-response to or failure to submit a complete CAP could result in further disciplinary action up to and including termination of contract.

G. IEHP may choose to delegate the Member grievance resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the Delegates.

1. Members may choose to directly address grievances to IEHP. IEHP will forward those grievances to the delegated organization for investigation only. Results must be returned by the due date. IEHP manages the grievance process and responds to Members.
2. The Delegate is responsible for establishing a grievance process in accordance with regulations mandated by DMHC, DHCS, and NCQA.
3. Grievances received directly by the delegated entity are reported to IEHP on a quarterly basis, reviewed by the Quality Management Committee, and forwarded to other IEHP committees as indicated.
4. IEHP retains ultimate responsibility for ensuring that the delegated entity satisfies all requirements of the grievance and appeal process.
5. On a periodic basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.

10. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

A. Member Grievance Resolution Process

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Date:		

10. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

B. Member Appeal Resolution Process

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP has established and maintains written procedures for the submittal, processing, and resolution of all Member appeals.[1]

B. A Member has the right to request an appeal within 60 calendar days of the date on the Notice of Action.[2,3]

PURPOSE:

A. To establish and maintain a timely and responsive procedure for submittal, process, and resolution of all Member appeals.

DEFINITIONS:

A. **Appeal:** An Appeal is defined as the review of an Adverse Benefit Determination to mean any of the following actions taken by IEHP or its IPA:[4,5]

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard and expedited resolution of grievances and appeals;
6. For a resident of a rural area with IEHP as the only Health Plan, the denial of the Member's request to obtain services outside of the network; and
7. The denial of a Member's request to dispute financial liability.

[1] Title 28, California Code of Regulations (CCR) § 1300.68(a)
[2] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 2, Section 2.1.2 Contractor Responsibilities
California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[4] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Enrollee Appeals and Grievances
[5] Title 42, Code of Federal Regulations (CFR) § 438.400(b)

B. **Expedited Appeal** – A request in which there is an imminent and serious threat to a Member's health, including but not limited to severe pain, potential loss of life, limb, or other major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.[6,7] This includes all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

C. **Notice of Action (NOA)** – An NOA is a formal letter from the Plan informing the Member of an Adverse Benefit Determination.[8]

D. **Notice of Appeal Resolution (NAR) –** An NAR is a formal letter from the Plan informing the Member of the outcome of the appeal of an Adverse Benefit Determination. The NAR informs the Member whether the Adverse Benefit Determination was overturned or upheld.[9]

PROCEDURES:

Member Rights and Options

A. The Member, a Provider acting on behalf of the Member, or the Member's authorized representative[10] may request an appeal within sixty (60) calendar days of the date on the Notice of Action via the following options:[11,12,]

1. By phone toll free at (800) 440-IEHP (4347) or (800) 718-4347 (TTY);[13]
2. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;
3. In person at 10801 Sixth St., Suite 120, Rancho Cucamonga, CA 91730-5987;
4. Via facsimile at (909) 890-5748; or
5. Online through the IEHP website at www.iehp.org;

B. Members that are minors, incompetent or incapacitated, may have an appeal requested on their behalf by the parent, guardian, conservator, relative, or other representative of the Member, as appropriate.[14]

C. Members are given reasonable opportunity to present evidence and testimony, and make legal

[6] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68.01
[7] 42 CFR § 438.410(a)
[8] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[9] 42 CFR § 438.408(d)(2)
[10] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[11] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[12] Ibid.
[13] 28 CCR § 1300.68(b)(4)
[14] California Health and Safety (Health & Saf.) Code § 1368(b)(2)

or factual arguments, in person as well as in writing, in support of their grievance or appeal.[15, 16]

D. Members have the right to request translation services to request their appeal in their preferred language or alternative format.[17]

   1. Alternative formats must also be provided to a family member, friend, associate, or authorized representative with a visual impairment or disability, if requested by the Member, in compliance with the Americans with Disabilities Act (ADA) effective communication requirements.[18]

E. Members have the opportunity before and during their appeals process to examine their case file, including medical records and any other documents and records considered during the appeals process. These are provided, free of charge, upon the Member's request by contacting Member Services.[19]

F. The Member, a Provider acting on behalf of the Member, or the Member's authorized representative may request a State Hearing in either of these situations:[20,21]

   1. Member received a Notice of Appeal Resolution stating that the initial adverse benefit determination has been upheld, and the request is made within one 120 calendar days from the date on the Notice of Appeal Resolution; or

   2. Member has exhausted IEHP's appeal process due to the health plan's failure to adhere to the appeal notice and timing requirements;[22] including failure to provide a fully translated notice; or

   3. Member has exhausted IEHP's appeal process due to the health plan's failure to provide adequate notice in a selected alternative format to the Member, their family member, friend, associate, or authorized representative, if required by the ADA.[23]

   IEHP notifies its Members that the State must reach its decision within 90 calendar days of the date of the request for standard State Hearing or within three (3) business days of the date of the request for expedited State Hearing.

G. Members have the right to request from DMHC an Independent Medical Review (IMR) of determinations based on lack of medical necessity, experimental/investigation, or emergency service. The Member is not required to request an IMR before, or use one as a deterrent to,

[15] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[16] 42 CFR § 438.406(b)(4)
[17] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04
[18] Ibid.
[19] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.4, Customer Service Call Center
[20] 42 CFR § 438.408(f)
[21] Ibid.
[22] 42 CFR § 438.408(d)(2)
[23] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.7 Notices

requesting a State Hearing.[24,25] The request for an IMR must however, be submitted before there is a final State Hearing decision.[26]

H. All IEHP staff and external IEHP committee members are required to sign a confidentiality statement agreeing not to disclose confidential information. However, IEHP may use or disclose a Member's individually identifiable health information without a Member's authorization as follows:[27]

1. For the direct provision of care or treatment of the patient;
2. For payment transactions, or health care operations, including billing for Member care;
3. For IEHP operational activities, including quality review;
4. If the request originates with a healthcare Provider who is involved in the treatment of the Member such as a pharmacy or a laboratory;
5. If the request is made to provide care to an inmate of a correctional facility; or
6. If the request is made by a representative of an accredited body.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, and annually thereafter and upon request.[28]

B. IEHP must assist Members requesting an appeal orally to prepare a written and signed appeal. However, IEHP must neither dismiss nor delay resolution of the oral appeal request for which a written and signed appeal was not received.[29,30] The date of the oral appeal establishes the filing date for the appeal.[31]

C. IEHP does not discriminate on the basis of race, color, national origin, sex, age, mental or physical disability or medical condition, ethnicity, ethnic group identification, national origin, ancestry, language, religion, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment.[32] [33] [34] [35]

[24] CA Health & Saf. Code § 1374.30(j)(1)
[25] Ibid.
[26] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[27] 45 CFR § 164.502(a)(1)(ii)
[28] 28 CCR § 1300.68(b)(2)
[29] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Covered California Enrollee Appeals and Grievances
[30] Ibid.
[31] 42 CFR § 438.406(b)(3)
[32] 42 CFR § 422.110(a)
[33] 45 CFR Part 92
[34] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91(e)(2)
[35] CA Government Code (Gov. Code) § 11135(a)

D. IEHP does not discriminate against any Member for filing a grievance or appeal.[36] IEHP does not discriminate, take, or threaten to take any punitive action against a Provider, who requests an expedited resolution or supports a Member's appeal.,[37]

E. IEHP ensures that Members with linguistic and cultural needs as well as Members with disabilities have access to and can fully participate in IEHP's appeal process by assisting those with limited English proficiency or with a visual or other communicative impairment.[38,39]

F. IEHP provides reasonable assistance throughout the appeal process which includes but is not limited to, providing and completing the forms, navigating the health plan's website, providing communication in threshold languages or in alternative format or languages upon request by the Member or Member's authorized representative, and access to interpreters for other languages, face-to-face, and/or telephonic translators.[40] IEHP staff may use the California Relay Services if necessary or requested by a Member with a hearing or speech disability.

G. IEHP provides Aid Paid Pending regardless of whether the Member makes a separate request when the Member timely files an appeal or State Hearing of a decision to terminate, suspend or reduce services. IEHP ensures that the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not medically necessary.[41,42,43,]

H. IEHP ensures that the person making the final decision for the proposed resolution of an appeal has neither participated in any prior decisions related to the appeal, nor is a subordinate of someone who has participated in a prior decision.[44] Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease make the final determination for all appeals.[45,46,47 48]

I. Fiscal and administrative concerns shall not influence the independence of the medical decision- making process to resolve any medical dispute between Member and Provider of service.[49]

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[36] 28 CCR § 1300.68(b)(8)
[37] 42 CFR § 438.40(b)
[38] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[39] 28 CCR § 1300.68(b)(3)
[40] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.67.04
[41] 42 CFR § 438.420
[42] California Welfare and Institutions Code (Welf. & Inst. Code), § 1366.23
[43] Ibid.
[44] 42 CFR § 438.406(b)(2)
[45] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution
[46] Ibid.
[47] 42 CFR § 438.406(b)(2)
[48] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.70.4
[49] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367

J. IEHP maintains all Member appeal requests, including medical records, documents, evidence of coverage or other information relevant to the appeal resolution in confidential electronic case files for 10 years.[50]

Provider Responsibilities

A. IPAs and Providers must ensure a Member's medical condition is at no time permitted to deteriorate because of delay in provision of care that a Provider disputes.

B. IPAs and Providers must respond to requests for medical records within 48 hours for standard appeals and by the specified due date for expedited appeals.

Member Appeal Notification Requirements

A. IEHP utilizes Department of Health Care Services (DHCS)-approved templates when informing Members of an Appeal resolution. All templates include the DHCS-approved "Your Rights" attachment, language assistance taglines and Non-Discrimination Notice. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.

B. All Member appeal correspondence, Member Appeal Forms, and the IEHP Appeal Resolution Process handouts meet all language and accessibility standards. This includes fully translating the NAR, including the clinical rationale for the health plan's decision, in the Member's required language.[51]

C. For partially translated appeal correspondence mailed during the implementation period, IEHP is required to meet the requirements, including but not limited to inserting a sentence that informs the Member, in their required language, how to obtain oral interpretation of the clinical rationale on an expedited basis, as well as, mailing a fully translated correspondence, with a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent.[52]

D. For Appeals not resolved wholly in favor of the Member, IEHP includes in its written response the reasons for its determination, including:[53]

   1. For determinations based on medical necessity, the criteria, clinical guidelines, or medical policies used in reaching the determination; or

   2. For determinations based on the requested service not being a covered benefit, the provision in the Evidence of Coverage or Member Handbook that excludes the service.

[50] California Welfare and Institutions Code (Welf. & Inst. Code), § 1009
[51] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04
[52] Ibid.
[53] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution

E. For Appeals resolved in favor of the Member, IEHP includes a clear and concise explanation of why the decision was overturned.[54]

Appeal Resolution Process

A. IEHP has a one level Appeal process, [55] for which IEHP's Grievance and Appeals Department is responsible (see "Attachments/Appeal Resolution Process – IEHP Covered – English" and "Appeal Resolution Process – IEHP Covered – Spanish" [56] in IEHP website).

B. IEHP's Grievance and Appeals Department is responsible for the resolution of Member complaints, including grievances and appeals. Appeal records include the following information:[57,58]

1. Dates of receipt and closure by IEHP;
2. Member's name and identification number;
3. IEHP staff person responsible for the case;
4. A description of the appeal;
5. A description of the action taken to investigate and resolve the appeal;
6. A description of the resolution;
7. Date of resolution notice; and
8. Copies of relevant information used in the case.

C. IEHP ensures appeals are resolved as quickly as the Member's health condition requires and do not exceed these regulatory timeframes:

1. Standard appeals are resolved within 30 calendar days of receiving the appeal.[59,60,61,62]
2. Expedited appeals are resolved no later than 72 hours of receiving the appeal.[63,64,65]

D. An acknowledgment letter to the Member within five (5) calendar days of receipt of the

[54] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Enrollee Appeals and Grievances
[55] 42 CFR § 438.402(b)
[56] https://www.iehp.org/en/providers/provider-resources?target=forms
[57] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 4, Section 4.6.2 Enrollee Appeals and Grievances
[58] 28 CCR § 1300.68(b)(5)
[59] California Welfare and Institutions Code (Welf. & Inst. Code), § 1374.33
[60] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution
[61] 28 CCR § 1300.68(a)
[62] 42 CFR § 438.408(b)(2)
[63] California Welfare and Institutions Code (Welf. & Inst. Code), § 1374.33
[64] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 13, Section 13.1 Dispute Resolution
[65] 42 CFR § 438.408(b)(3)

appeal,[66] which includes:[67]

1. The appeal receipt date;
2. Name of the IEHP representative who may be contacted regarding the appeal; and
3. The toll-free telephone number, and address of the IEHP representative who may be contacted about the appeal.

E. Expedited appeals do not require Acknowledgement Letters, as these are resolved within 72 hours. Oral notice of resolution of an expedited appeal is provided within 72 hours.[68,69,]

1. Within twenty-four (24) hours of receiving the appeal, IEHP notifies the Member whether or not the appeal met the criteria for expedited review, as defined in this policy. If criteria is met, the Member is informed of the shortened timeframe to submit information related to their appeal, and of their right to notify the of their appeal.[70]
2. If the appeal does not meet the criteria for expedited review, IEHP informs the Member orally within 72 hours of appeal receipt, followed by a written notice. Both oral and written notices include notification of transfer to the standard 30 day appeal process,[71] and the Member's right to notify DMHC of the expedited review request.

F. If the case involves a decision that is not within the IEHP Medical Director's expertise, an additional opinion is obtained from an independent physician reviewer in the appropriate specialty prior to review by an IEHP Medical Director. IEHP ensures that practitioners or subordinates of the practitioners involved in a denial decision are not involved in the resolution of an Appeal involving the prior decision,[72] although the practitioner who made the initial adverse determination may review the case and overturn the previous decision.

G. The Appeal determination will either be to uphold or overturn the NOA.

1. If a denial is upheld, the Member is notified of their right to request a State Hearing within one-hundred twenty (120) calendar days from the date of Notice of Appeal Resolution (NAR); right to request and receive continuation of benefits while State Hearing is pending; and right to request an Independent Medical Review (IMR) from DMHC for determinations based on lack of medical necessity, experimental/investigation or emergency service.[73,74]
2. If a denial is overturned, services are authorized as expeditiously as the Member's health condition requires and no later than 72 hours from the date of the Notice of Appeal

[66] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.43.3
[67] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.43.3
[68] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.02
[69] Ibid.
[70] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68.01
[71] 42 CFR § 438.410(c)
[72] 42 CFR § 438.406(b)(2)
[73] California Welfare and Institutions Code (Welf. & Inst. Code), § 1370.4
[74] CA Health & Saf. Code § 1374.30(j)(1)

Resolution.[75,7677]

H. Upon notification that DHCS, through a State Hearing, has reversed IEHP's appeal determination, services are authorized as expeditiously as the Member's health condition requires and no later than 72 hours from the date the health plan receives notice reversing the determination.[78]

I. Upon notification that DMHC, through the IMR process, has ruled a disputed health care service as medically necessary: IEHP immediately contacts the Member and arranges to authorize the services as expeditiously as the Member's health condition requires and no later than five (5) business days of receiving written decision from DMHC.[79]

Monitoring and Oversight

A. IEHP may choose to delegate the Member appeal resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the Delegates.

1. The Delegate is responsible for establishing an appeal resolution process in accordance with regulations mandated by DMHC, DHCS, and NCQA.
2. IEHP retains ultimate responsibility for ensuring that the Delegate satisfies all requirements of the grievance and appeal process.
3. On a periodic basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Date:		

[76] 42 CFR § 438.424
[77] California Welfare and Institutions Code (Welf. & Inst. Code), § 1374.30
[78] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.67.02
[79] CA Health & Saf. Code § 1374.34(a)