VENTURA COUNTY
HEALTH CARE PLAN

GRIEVANCE AND APPEAL PROGRAM DESCRIPTION

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Program Description

Medical Director Approval

Medical Director Signature

2/26/25
Approval Date

Administrator Approval

Administrator Signature

2/26/25
Approval Date

Credentialing Committee Approval

Chairperson Signature

1/13/25
Approval Date

Pharmacy and Therapeutics Committee Approval

Chairperson Signature

2/18/25
Approval Date

Utilization Management Committee Approval

Chairperson Signature

2/20/25
Approval Date

Quality Assurance Committee Approval

Chairperson Signature

2/25/25
Approval Date

Standing Committee Approval

Chairperson Signature

3/13/25
Approval Date

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GRIEVANCE AND APPEAL PROGRAM DESCRIPTION

Purpose and Scope

VCHCP shall implement a Grievance and Appeals Program that meets the requirements of the Knox-Keene Health Care Service Plan Act of 1975 and the regulations promulgated thereunder. VCHCP will ensure that a mechanism exists to process Member Grievances and Appeals in a consistent manner.

VCHCP recognizes that, under certain circumstances, our performance or that of our contracted providers, may not agree with or match our members' expectations. Therefore, the Plan has established a system for the Plan Members to file a grievance/complaint or appeal. We endeavor to assure our members of their rights to voice complaints and appeals of any adverse determination of complaints, and to expedite resolutions.

None of the information presented in this policy pertains to provider dispute resolution. See Provider Dispute Resolution Mechanism (PDRM) document for details of this process.

Guidelines

VCHCP has developed its grievance/complaint and appeal system so that it provides reasonable procedures that ensure adequate consideration of our members' grievances/ complaints and appeals in accordance with statutory requirements. (The Plan seeks the approval of its process by the DMHC).

The Director of Member and Provider Services of the Plan, has been designated as having primary responsibility for the Plan's grievance and appeal system to ensure appropriate oversight and administration of all aspects, including compliance, monitoring, reviewing, and reporting to identify emerging patterns of grievances and improve plan policies and procedures.

The Grievance/Appeal Coordinator is responsible for day-to-day activities, which include the initial review, research, and logging of all standard and urgent complaints, as outlined in the Grievance and Appeal Process Desk Procedure.

VCHCP documents research, interim and final responses to the Member, as well as telephonic and written responses to members' concerns through the grievance/complaint and appeals process. This ensures that all concerns by Plan members are resolved in a fair and timely manner. This process has been developed to address various levels of concerns by Members including general inquiries, Grievances, and Appeals procedures. It also facilitates the categorizing of member concerns via an on-line system.

It often requires a series of events to truly identify one overall situation or trend. Accordingly, the Grievance/Complaint and Appeals tracking system provides information that empowers the Plan with the opportunity to continually monitor and improve the level of care and services it provides to Members. Trends are analyzed and reported quarterly to the Member/Provider Experience Committee (MPEC), QA, and Standing Committees.

Members have the right to voice a concern about the benefits, services, access, continuity of care and quality of care provided by the Plan, Plan Providers, and Plan Facilities. VCHCP, its Plan Providers and Facilities will not discriminate against members who have chosen to file a grievance. The fact that a member submits a grievance/complaint or appeal to VCHCP will not affect in any way the manner in which the member is treated by

VCHCP or receives services from contracting providers. If VCHCP discovers that any improper action has been taken against such member or subscriber, immediate steps will be taken to rectify the situation and prevent such conduct in the future.

1. The Plan shall conduct a thorough investigation of the incident.
2. The Plan shall determine whether or not adverse action was taken against such member or subscriber.
3. The Plan shall take disciplinary action against the offending Plan employee(s) who took adverse action against such member or subscriber.
4. If no adverse action was taken against such member or subscriber, the Plan shall close the investigation and save all logs, interview notes, the conclusion, and all other evidence gathered as part of the investigation in a secure electronic storage to protect private information which may have been accumulated during the investigation.

Enrollees have the right to submit grievances to the plan and the DMHC in accordance with Section 1368 and Rule 1300.68 for failure to provide trans-inclusive health care.

Trans-inclusive health care is defined as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

When an enrollee submits a complaint against a member of the plan's staff for failure to provide trans-inclusive health care, and a decision is made in favor of the enrollee, the plan staff will be required to retake the evidence-based cultural competency training within 45 days of the decision.

Enrollees are encouraged to review VCHCP's benefits and exclusions carefully prior to selecting our benefit Plan for their health care needs. Certain health care services, for example, purely cosmetic surgery, are not covered benefits of the Plan. Services, medications, devices, or procedures that do not represent approved medical practices are also excluded from coverage by VCHCP. All such determinations for coverage are made by the Medical Director of the Plan.

Definitions

Appeals (coverage related: Any oral or written requests made by a member or their authorized representative to reconsider an initial determination. Appeals may be requested for a denial of claims, denial of benefit or other denial of coverage, but need not be limited to these.

Appeals (not coverage related): Any oral or written requests made by a member or their authorized representative to reconsider a decision that was not related to coverage.

Date of Receipt: The date/time of receipt of an appeal request is defined as the date/time that the request is received, in accordance with the state requirements and NCQA standards. The following describes the date/time used to note the date/time a request was made for a request for an appeal:

- If received by U.S. mail, the date/time the document is physically received at the VCHCP office. The date stamp is added to the document by the Member Services Representative responsible for receiving incoming mail.

- If received by fax, the date/time indicated by the fax transmission report.
- If received verbally by phone, the date/time the call was made with the request.
- If received verbally by voicemail, the date/time the initial message was left in the voicemail system.
- If received electronically (email, website, or portal), the date/time the complaint was sent.

Date of Written Notification: The date/time of written notification is defined as the date/time that the notification was sent, in accordance with the state regulatory requirements and NCQA standards. The notification date is also the letter date.

Exempt Grievance: Grievances that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.

Expedited Review: When there is a time sensitive situation for cases involving 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.

Grievance/Complaint: A grievance/complaint means a written or oral expression of dissatisfaction regarding the plan and/or provider by either a Plan member or their representative, including the member's provider(s). Where the Plan cannot distinguish between a grievance/complaint and an inquiry, the Plan will consider the inquiry to be a grievance/complaint.

Grievances/Complaints may include, but are not limited to, concerns about quality of care, access to care, delay of care, and denial or modification of health care services.

Grievant: one who files a grievance with VCHCP

Resolved: Grievance/complaint or appeal has reached a final conclusion (no pending Member appeals).

Standard Grievance: Grievances that are not categorized as Exempt or Urgent.

Urgent Grievance: Grievances involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Grievances relating to cancellation, rescission, or nonrenewal will also be handled as urgent.

PROCEDURES FOR EXEMPT GRIEVANCES/COMPLAINTS

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are considered exempt grievances. A call log is created for each exempt grievance, and the call log includes the following information: the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. See the Exempt Grievance Desk Procedure for specific details. Exempt Grievances are included in the quarterly reporting process as outlined in the Grievance and Appeal Reporting Desk Procedure.

All Quality of Care complaints are referred to the Medical Director, or designee, for review, who will make a determination as to whether the grievance will be handled as a Potential Quality Issue (PQI). See the Quality Management Program Description and supporting policies for complete details.

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PROCEDURES FOR STANDARD GRIEVANCES/COMPLAINTS

Information regarding the grievance/complaint procedures for receiving and resolving grievances/complaints is provided to members in the Annual and New Member Packets and is also available in the Plan's Evidence of Coverage, which is available on the Plan's website and will be sent to members upon request. Members may register grievances/complaints with VCHCP by form, letter, fax, in person, email, online, by calling or writing:

Ventura County Health Care Plan
Attn: Grievance Coordinator
2220 E. Gonzales Rd. Ste. 210-B
Oxnard, CA 93036
Phone: (805) 981-5050 or **(800) 600-VCHP**
Fax: (805) 981-5051
VCHCP.Memberservices@ventura.org

For free Language Assistance services or cultural assistance, including interpreter services, call VCHCP at (805) 981-5050. If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance by calling TDD/TTY at (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish. In addition, the Plan's website provides an on-line form that an enrollee may use to file a grievance on-line via a secure portal. The link to this on-line Grievance Form is found on the right-hand side of the Plan's web portal page, https://www.vchealthcareplan.org/members/memberIndex.aspx

VCHCP validates the on-line process is working correctly at least monthly.

A member may appoint an Authorized Representative, such as a legal guardian, conservator or relative, who can also submit a grievance to the Plan.

This appointment must be in writing. Members can obtain an Authorized Representative form to submit by calling Member Services or visiting VCHCP in person.

The following persons may be submitted and considered as an authorized representative:

- A friend, relative or legal representative
- A parent of a child under 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of relevant information.
- A court- appointed guardian, except the ward must appoint the court-appointed guardian as authorized representative is the ward has the legal right to control release of relevant information.
- A court-appointed conservator
- An agent under a currently effective health care proxy, to the extent provided under state law.

A member's provider can also submit grievances to the Plan and/or the DMHC. This includes a grievance submitted by a provider regarding a denial for coverage of a nonformulary drug, prior authorization request, or step therapy exception. VCHCP requires providers to make available, upon request, a grievance/complaint form to the member, and should maintain a supply of such forms in their offices. This information is included in the Provider Operations Manual which is distributed on an annual basis, and is also part of the provider site visit process.

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The Member Grievance Procedure is designed to provide a meaningful, dignified and confidential process for the hearing and resolving of problems and complaints. VCHCP makes grievance forms and a description of the grievance procedure readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. VCHCP helps members in filing a grievance, when needed, and this includes providing language assistance, as well as assistance for those with disabilities, including hearing and visual impairments. Grievance forms shall be provided promptly upon request by any of the above.

A Member may initiate a grievance in any form or manner (form, letter, fax, telephone call, or online to the Member Services Department), and when VCHCP is unable to distinguish between a complaint and an inquiry, the communication shall be considered a complaint that initiates the Member Grievance Procedure. Members are advised, via statement on the grievance/appeals form, that after participating in the process for at least 30 days, they may submit the grievance to the DMHC for review. Further, the member is advised via statement on the grievance/appeals form, that they do not need to complete the 30 day process if the case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function.

The Plan provides written acknowledgment of a Member's standard grievance and ongoing investigation within five (5) calendar days of receipt, unless the grievance is received by telephone and can be resolved within the same day. For those grievances/complaints that can be resolved within 5 calendar days or less of receipt, the written statement to the complainant of the resolution will stand as the receipt of notification and resolution. The Plan provides for the receipt, handling, and resolution of grievances, including a written response to a standard grievance, within thirty (30) calendar days. The notification letter providers members with their appeal rights. If, however, the case 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, the Plan shall provide an expedited review. The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three calendar days from receipt of the grievance. See expedited review section below.

Written documentation is begun the date the complaint is received in the Plan's office. Assistance is provided to those members who have limited English proficiency through a bilingual staff member or through a language assistance line. The member's demographics are checked for accuracy in the system, the complaint is documented and if reported through a phone call, summarized and read back to the member. Documentation includes the member's reason for the complaint, along with the actions taken to investigate and respond to the complaint, including the member's previous complaint history and follow-up activities associated with the complaint. Grievances are appropriately categorized, and notes and comments are added to the Grievance document as the investigation process is conducted by researching all issues relevant to the complaint. The process may include review by the Director of Member and Provider Services. See Grievance and Appeal Process Desk Procedure. Upon conclusion/resolution, the document log is completed with all dates and actions included.

All Quality of Care complaints are referred to the Medical Director, or designee, for review, who will make a determination as to whether the grievance will be handled as a Potential Quality Issue (PQI). See the Quality Management Program Description and supporting policies for complete details.

Complaints are tracked to identify any trends. Additionally, the Director of Member and Provider Services may request review by the Medical Director or designee for any other appropriate issue. When appropriate, VCHCP will

bring complaints to the attention of providers, request appropriate corrective actions from them, and follow-up to see that necessary changes have been implemented.

Members may file grievances for up to 6 months (180 calendar days) following any event or action that is subject to the Members dissatisfaction.

Records of grievances/complaints are maintained by the Plan for no less than 5 years. Copies of information that the Plan is required to maintain for five years shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the Plan relied to reach its decision.

If the organization cannot resolve a complaint within the time frame stated in its policies or cannot notify the member of the final decision for legal or statutory reasons, at a minimum, it will notify the member that the complaint was received and investigated.

For further details of the grievance process, see Grievance and Appeal Process Desk Procedure.

EXPEDITED REVIEW OF URGENT GRIEVANCES

In addition to the procedures outlined in the previous section, the Plan's grievance/complaint system also includes procedures for the expedited review of grievances for time sensitive situations for cases involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function. Grievances relating to cancellation, rescission, or nonrenewal will also be handled as urgent.

When the Plan is notified of a case that requires urgent review, the Plan will immediately advise the Plan Member of their right to notify the DMHC of the urgent grievance. Further, the Plan shall, no later than 72 hours from the receipt of the urgent grievance, notify the Plan Member and the DMHC in writing of the disposition or pending status of the urgent grievance.

Policy

- The Plan has established a system that is capable of receiving requests from the DMHC to respond to urgent grievances/complaints.
- The system includes expediting its review when the complainant, an authorized representative, or treating physician provides notice to the Plan of the grievance/complaint.
- The Plan provides to enrollees and the DMHC an available qualified representative (Medical Director on Call and/or Administrator on Call) 24 hours a day, 7 days a week to handle urgent grievances.
- The Plan Medical Director or Assistant Medical Director (also holding an unrestricted California medical license) may authorize health care services, and thereby make financial decisions for expenditure of funds on the plan's behalf.
- Upon receipt of a grievance/complaint considered to be an urgent grievance by the member or the member's representative, the plan will immediately inform the complainant of his/her right to notify the Department of Managed Health Care (DMHC).
- Before responding, the plan representative may consult with plan personnel or others to obtain the information necessary to make an optimal decision under the particular circumstances. The member's medical condition shall be considered when determining the response time.
- During normal work hours the Plan will respond to DMHC within 30 minutes of the initial contact, and within 1 hour during non-work hours.
- The plan will provide a written response of the disposition or pending status of an urgent grievance to the

member (and to the DMHC when notified of the complaint) within 3 days of receipt.

- An extension of up to 10 additional working days beyond the 72 hours is possible if the extension of time benefits the member, such as allowing for additional diagnostic tests or consultations if agreed to by the member.
- An extension can also be provided if the member requests additional time in order to supply VCHCP with additional information for making a decision.
- The plan will notify the DMHC thirty days in advance of implementing revisions to this procedure.
- Expedited reviews also include grievances for experimental procedures for the terminally ill

Procedure for Responding to the DMHC

A call will be made to VCHCP by the DMHC's California HMO Help Center, the area responsible for handling urgent grievances. Below are instructions to be used by the DMHC to activate the Plan's process for handling urgent grievances.

DMHC Access Procedure for Regular Business Hours

- During regular business hours (Monday through Friday, from 8:30 a.m. to 4:30 p.m., excluding County-observed holidays), the DMHC will call VCHCP's main number: **1-(805) 981-5050 or toll-free 1-(800) 600-VCHP** and access option 1, Member Services.
- The Member Service representative will locate the person responsible for handling urgent grievances.
- The designated authorized administrative staff includes: the Medical Director, Plan Administrator, Director of Member and Provider Services, and/or the QA Manager for the Plan.
- All designated authorized staff are available via work numbers, cell phones, and email addresses.
- The designated authorized administrative staff will contact the DMHC within 30 minutes.

After-Hours DMHC Access Procedure

- After regular business hours, and on weekends and County-observed holidays, the DMHC will call VCHCP's main number **1-(805) 981-5050 or toll-free 1-(800) 600-VCHP** access option 3 and follow the instructions for the Medical Director and/or Plan Administrator on Call.
- Option 3 will connect the caller to the Plan's after hour answering service.
- The DMHC will ask the answering service operator to contact the person responsible for handling urgent grievances, the Medical Director and/or Administrator on Call.
- The Plan's Medical Director and/or Administrator on Call will contact the DMHC within one hour.
- Example of On-Call Duty Roster is attached.

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Coordination of Plan Decision-Making

- The Medical Director and/or Administrator will communicate to the Utilization Review Department by the next business day, any authorization decisions made on behalf of the plan.
- If the case requires follow-up and decision-making over multiple duty roster shifts, each plan representative involved shall separately notify the plan.
- The UR RN shall document these decisions in the QNXT System, generate and send authorizations to the member and provider(s).
- The UR RN shall immediately inform both the Medical Director and Administrator, if these individuals are not already involved in the case.
- The plan will provide a written response of the disposition or pending status of an urgent grievance to the member and to the DMHC within 3 calendar days of receipt.
- If the complaint has been resolved in the member's favor, the authorization shall serve as the written response.
- If the status of the complaint is pending, the Medical Director will normally prepare the required written response.
- While the DMHC is handling the review of an urgent grievance, the plan is required to notify the DMHC of any impending changes in health care services authorized (such as a hospital discharge) that are opposed by the member or the member's representative.

Plan Personnel Responsible for Handling Urgent Grievances

Contact Person:
Christina Woods, Director of Member and Provider Services
During Business Hours:
Member Services: (805) 981-5050 - Toll-free: (800) 600-VCHP
E-mail: Christina.Woods@ventura.org
Office: (805) 981-5086
Fax: (805) 981-5051

Alternate Contact Person:
Faustine DeLaCruz, RN, Director of Health Services
During Business Hours:
UM Services: (805) 981-5060 - Toll-free: (800) 600-VCHP
E-mail: Faustine.DelaCruz.@ventura.org
Office Phone: (805) 981-5058

Medical Director:
Howard Taekman, M.D., Medical Director
During Business Hours:
Customer Service: (805) 981-5024
Toll-free: (800) 600-VCHP
E-mail: Howard.Taekman@ventura.org
Office Phone: (805) 981-5024

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GRIEVANCES AND APPEALS PERTAINING TO TERMINALLY ILL MEMBERS

If a grievance/complaint is received pertaining to a member with a terminal illness, the Plan shall provide the member with a statement setting forth the specific medical and scientific reasons for denying the coverage.

The Plan shall provide the member with a description of alternative treatments, services and/or supplies covered by the Plan.

The member shall also, within five (5) days, be provided with copies of the Plan's Grievance procedures and Complaint forms, with an offer to attend a conference with the Plan within 30 calendar days.

GRIEVANCES FOR TERMINATIONS FOR NON-RENEWALS, RESCISSIONS, AND CANCELLATIONS

A grievant who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the grievant alleges to be improper to submit a grievance to VCHCP. All grievances received by VCHCP are referred to the grievance coordinator for handling. A grievant may also submit a grievance to the DMHC.

VCHCP shall process grievances relating to cancellation, rescission, or non-renewal as expedited grievances. Please see page 7 under Expedited Review of Urgent Grievances for further clarification.

When VCHCP receives a grievance relating to cancellation, rescission, or nonrenewal, VCHCP shall provide the DMHC and the grievant with a disposition or pending status on the grievance within three (3) calendar days of receipt of the grievance by the VCHCP.

When VCHCP is notified that the DMHC has accepted the complaint regarding a cancellation, rescission, or nonrenewal, within one business day of that notification, VCHCP will provide the DMHC with a copy of all information the plan used to make its determination and all other relevant information necessary for the DMHC's review.

If the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, including, but not limited to, all notice and timing requirements in this Article, the Director shall order reinstatement, in accordance with California Code of Regulations, title 28, section 1300.65(d), or direct the plan not to cancel coverage.
If the DMHC determines that the cancellation, rescission, or nonrenewal was proper, but the effective date was in violation of the requirements, VCHCP may be directed to adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the grievant.

Continuation of Coverage

If the grievant files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, VCHCP shall continue to provide coverage to the grievant pursuant to the terms of the plan contract while the grievance is pending with VCHCP and the DMHC.

During the period of continued coverage, the grievant remains responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the plan contract.

If the DMHC determines that the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, and the cancellation date complies with all laws and regulations, including California Code of Regulations, title 28, section 1300.65.2(a)(5). The grievant shall be responsible only for the required premium and cost sharing obligations (deductibles and copays) incurred during the continued coverage period.

If it is determined that the rescission is consistent with existing law, VCHCP shall return all premiums paid by the grievant. The grievant is responsible for the cost of all medical services received after the effective date of the rescission.

Reinstatement of Coverage

If the DMHC determines that the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the grievant submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, VCHCP may be directed to reinstate the grievant, retroactive to the effective date of cancellation, rescission, or nonrenewal.

Within 15 days after receipt of the order for reinstatement, VCHCP shall either request an administrative hearing from the DMHC or reinstate the grievant.

If VCHCP is directed to reinstate coverage, VCHCP shall be liable for the expenses incurred by the grievant for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the grievant's Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. VCHCP shall reimburse the grievant for any medical expenses incurred by the grievant pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

The grievant shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. The grievant must pay all outstanding premiums before reinstatement.

Notice of Right of Enrollee to Submit a Grievance:

The following language regarding the right of an enrollee, subscriber, or group contract holder to submit a grievance to the Department of Managed Health Care must appear in at least 12-point font when required by a section in this Article:
RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1) - THE ENROLL, SUBSCRIBER, OR GROUP CONTRACT HOLDER MAY SUBMIT A GRIEVANCE TO VCHCP.

* The enrollee, subscriber, or group contract holder may submit a grievance to VCHCP by calling (805) 981-5050, online at http://www.vchealthcareplan.org/, or by mailing your written grievance to:

Ventura County Health Care Plan
2220 E. Gonzales Rd. Ste. 210-B

* The enrollee, subscriber, or group contract holder may want to submit your grievance to [plan] first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

* VCHCP will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from VCHCP within three (3) calendar days, or if you are not satisfied in any way with VCHCP's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2.

OPTION (2) – THE ENROLL, SUBSCRIBER, OR GROUP CONTRACT HOLDER MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

* The enrollee, subscriber, or group contract holder may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.

* The enrollee, subscriber, or group contract holder may submit a grievance to the Department of Managed Health Care online at:
WWW.DMHC.CA.GOV

* The enrollee, subscriber, or group contract holder may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:
HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

* The enrollee, subscriber, or group contract holder may contact the Department of Managed Health Care for more information on filing a grievance at:
PHONE: 1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241

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APPEAL RIGHTS

This applies to both coverage appeals and appeals of decisions that are not about coverage. Members are notified of their appeal rights at several times during the grievance process, including upon the initial denial.

VCHCP provides members with written responses to appeals. Responses include a clear and concise explanation of the reasons for the response.

- Grievances involving the delay, denial, or modification of services based on a determination in whole or in part that the service is **not medically necessary:** for grievances involving these issues VCHCP will, in its written response, describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity (which will be substantiated by our medical necessity criteria). It also includes that the determination may be considered by the Department's independent medical review system. An application will be provided with an envelope addressed to the DMHC in Sacramento.
- Grievances involving a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered **benefit** under our Plan contract: for grievances involving these issues, VCHCP, in its written response, will clearly specify the provisions in the Evidence of Coverage that exclude that coverage.

The Department of Managed Health Care (DMHC) maintains a program that assists consumers with resolution of problems and complaints involving HMOs. Members are advised of the Department's telephone number, the Department's TDD line, the plan's telephone number, and the Department's Internet address in 12-point boldface type in the following regular type statement on the initial Grievance/Complaint form, in their Evidence of Coverage (EOC), on the VCHCP five-day notification correspondence, disposition correspondence, and in notices relating to denial of services or appeals.

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-805-981-5050**) or (**1-800-600-8247**) and for hearing impaired members: TDD to Voice (**1-800-735-2929**); Voice to TDD (**1-800-735-2922**) for English or (**1-800-855-3000**) for Spanish and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

In addition, the following language is included in all appeal disposition letters, when the request for services is denied:

You may obtain a free of charge copy of the guideline, protocol or other similar criterion on which the denial decision was based, upon request, by calling VCHCP at 805-981-5050 or 800-600-8247. For hearing impaired members: TDD to Voice (800) 735-2929; Voice to TDD (800) 735-2922 for English or (800) 855-3000 for Spanish.

You have the right to ask for and receive (for free) access to and copies of all documents, records and other information related to your case, as well as copies of any internal rule, guideline or protocol that we used to make this decision. You also have the right to ask for and receive (for free) an explanation of the scientific or clinical judgment that we relied on in making this denial decision, if applicable.

To request copies, please send a separate written request to:

Ventura County Health Care Plan
Attention: Utilization Management Department
2220 East Gonzales Rd Suite 210B
Oxnard, CA 93036

If you are not satisfied with the Plan's decision, you may file a grievance with the Department of Managed Health Care (DMHC). In addition, if the Plan's decision is based on the fact that the requested service is not a covered benefit, but you believe the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

Members are advised at the time of the complaint that they do not need to complete the 30-day process if the case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function.

A member's legal guardian, conservator, or relative can also submit appeals to the Plan or the DMHC.

A member's provider can also submit grievances to the Plan and/or the DMHC. This includes an appeal submitted by a provider regarding a denial for coverage of a nonformulary drug, prior authorization request, or step therapy exception.

Members are expected to use the Plan's appeal procedures first to attempt to resolve any dissatisfaction. Please see the section below on appeals for details. If the appeal has been unresolved for more than 30 calendar days or was not satisfactorily resolved by the plan, the member may seek assistance from DMHC.

Providers, including participating and non-participating physicians may assist the member in submitting a complaint to the department for resolution and may advocate the member's cause before the department. No provider may be sanctioned by VCHCP for giving such assistance to a member.

The DMHC has 30 days from receipt of an IMR request to send the member and VCHCP a written notice of their determination (which the DMHC refers to as the notice of "final disposition of the grievance"). (See IMR Policy, QA Program).

There are some services that, if disputed, are not eligible for the IMR system. However, the DMHC is given the authority to require VCHCP to promptly offer the service, or reimburse the member for it if they determine that it was a covered service and was medically necessary

Members are also allowed to request voluntary mediation with VCHCP prior to exercising their right to submit a grievance to the DMHC. The DMHC still allows the member to submit a grievance to them after completion of mediation.

PROCEDURES FOR APPEALS

These procedures apply to both coverage appeals and appeals of decisions that are not about coverage.

Appeals made to the Plan for adverse decisions of grievances and complaints are handled primarily by the Member Services Department. Appeals arising from adverse coverage decisions are generally handled by the UM department and are addressed in the Treatment Authorization Request: Denial, Modification and Appeal Process document.

Members are notified of the appeals process in the Annual and New Member Packets, and this information is also included in the Evidence of Coverage (EOC). All members receive information on how to obtain a copy of the EOC on an annual basis. The EOC is located on the VCHCP website and members can also obtain a hard-copy, upon request, by contacting Member Services. This information includes the Plan's local and toll-free number, access to telephone relay systems, notification of linguistic services and cultural assistance. Also included is the DMHC's appeals process, the Independent Medical Review System and the DMHC's toll-free number and website address.

A member, a member's legal guardian, conservator, or relative can submit an appeal to the Plan or to the DMHC.

VCHCP will retain records of appeals for a period of at least 5 years. Information that the Plan is required to maintain included a copy of all medical records, documents, evidence of coverage and other relevant information upon which the Plan relied to reach its decision.

As stated in the Appeal Rights section, members are expected to use the Plan's appeal procedures first to attempt to resolve any dissatisfaction. If the appeal has been unresolved for more than 30 calendar days or was not satisfactorily resolved by the plan, the member may seek assistance from DMHC.

Appeals may be received by the Plan in writing, by telephone, fax, email, or online through the website.

Written documentation is entered as a call log in the member's record in the QNXT system and is begun the date the appeal is received in the Plan's office. Documentation includes the member's reason for appealing the previous decision, along with the actions taken to investigate and respond to the appeal, including the member's previous appeal history and follow-up activities associated with the appeal. Assistance is provided to those members who have limited English proficiency through a bilingual staff member or through a language assistance line. The member's demographics are checked for accuracy in the system, the appeal is documented through call tracking in the QNXT system and if reported through a phone call, summarized and read back to the member. Appeals are appropriately categorized and notes and comments are added to the appeal file as the investigation process is

conducted by researching all issues relevant to the appeal, including reviewing the original appeal and its disposition and additional information submitted and any clinical care aspects. The appeal, also called a second level review, is evaluated by the appropriate individual, usually the Medical Director, his designee, the Director of Member and Provider Services or Director of Health Care Services. This cannot be the same individual that made the initial determination regarding the grievance. Upon conclusion/resolution, the document log is completed with all dates and actions included.

The Plan provides written acknowledgment of a member's appeal within five (5) calendar days of receipt. Appeal determinations will be made within 30 calendar days of the receipt of the appeal. The member will be notified in writing, by that time, of the Plan's decision.

As with a grievance, an adverse decision on a first appeal/second level review can be appealed further. If the first appeal has been unresolved for more than 30 calendar days or was not satisfactorily resolved by the plan, the member may seek assistance from DMHC, as stated in the appeal notification letter and the EOC.

Urgent appeals are ones involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Appeals relating to cancellation, rescission, or nonrenewal will also be handled as urgent.

For urgent appeals, the same process applies as with an expedited review. See prior section on Expedited Review of Urgent Grievances.

MEDIATION

The member and dependents may request that an unresolved disagreement, dispute or controversy concerning any issues including the provision of medical services, arising between the member and dependents, the member's heirs-at-law, or personal representative, and VCHCP, its employees, Participating Providers, or agents undergo voluntary mediation.

If a member seeks voluntary mediation, he or she must send written notice to VCHCP's Administrator (address above) containing a request for mediation and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that the member has previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure. VCHCP will agree to such reasonable request for mediation and any request for binding arbitration (both as described below). The use of mediation services shall not preclude the right to submit a grievance or complaint to the DMHC (as described below) upon completion of mediation.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

After participating in the grievance process for at least thirty (30) calendar days, or less if the member believes there is an imminent and serious threat to his or her health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, and the DMHC agrees there is such a threat to his or her health, or in any other case where the DMHC determines that an earlier review is warranted, the member may register unresolved

disputes for review and resolution by the DMHC. Included in member communication, as appropriate, is the required language pursuant to Knox-Keene Health Care Act section 1368.02(b) and California Health and Safety Code section 1300.68(d)(4).

ARBITRATION

1. Mandatory arbitration is the final process for the resolution of any dispute that may arise. As a condition of enrolling with VCHCP, the member is agreeing to have any issue or dispute concerning the provision of services under the Agreement, including any issue of medical malpractice, decided by a neutral, independent arbitrator and the member is giving up his or her right to a jury or court trial.
2. Arbitration shall be conducted according to the California Arbitration Act, Code of Civil Procedures, and 1280 et seq. This will apply to any controversy, as noted above, including and not limited to the employer, subscriber, family members (whether minors or adults), the heirs-at-law or personal representatives of a subscriber or family member or network providers (including any of their agents, employees or providers).
3. Each party shall bear its/his own arbitration costs and attorney's fees, with the parties equally sharing the fees of one arbitrator.
4. The decision of the arbitrator shall be final and binding.
5. If the member seeks arbitration, he or she must send written notice to VCHCP's Administrator containing a demand for arbitration and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that he or she has previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure.

QUALITY ASSURANCE AND REPORTING

Overview

In order to evaluate opportunities for administrative practice improvements, referral process improvements, and educational opportunities for members and physicians, VCHCP collects and analyses member satisfaction information, including, but not limited to, appeals and grievance/complaint data, summary of processes and summary of disposition and outcomes (see the Grievance and Appeal Reporting desk procedures for complete details).

On a quarterly bases, VCHCP reports the results of these evaluations to the Member/Provider Experience (MPEC), Quality Assurance (QAC), and the Standing Committees, which may make recommendations for change based on these results. The Plan reports results and requests that the MPEC Committee make recommendations for changes, if any, based on these results.

Internal Reporting

1. VCHCP maintains a written record (log) of all grievances received either orally or in writing from members.
2. The written record, at a minimum, includes the date, identification of the member, identification of the individual recording the grievance (if different than the member), the Plan staff who initiated the records, Plan staff who reviewed and/or resolved the issues, actions taken to resolve the issue(s), and the

disposition(s) of the resolution(s), inclusive of dates, and record of 5-day notification, interim notification, and 30 day resolution response.

3. All exempt, standard, and urgent grievances/complaints and appeals are initially categorized in accordance with the categories below. All grievances that involve a potential quality of care issue are routed to the Medical Director or his/her clinical designee for resolution and follow-up.

DMHC Categories	NCQA Categories
Access	Access
Coverage Disputes	Billing and Financial Issues
Medical Necessity	Quality of Practitioner Office Site
Quality of Care	Quality of Care
Quality of Customer Service	Attitude and Service

4. VCHCP's grievance system includes a system of aging grievances that are pending and unresolved for 30 days or more and summary reports in various categories for tracking and trending data analysis.
5. A written record of tabulated grievances, summary of process, and summary of disposition and outcomes are reviewed by the Member/Provider Experience Committee (MPEC) and the Standing Committee quarterly.

External Reporting

1. VCHCP also provides the DMHC ("Director") with a quarterly report of grievances pending and unresolved for 30 or more days within the Plan's grievance system.
2. The report shall not include complaints filed outside the Plan's grievance system in other complaint resolution procedures.
3. The quarterly report shall be prepared for the quarter ending on March 31st, June 30th, September 30th, and December 31st of each calendar year.
4. The quarterly report shall not include personal or confidential information with respect to any enrollee.
5. The Plan's Director of Member and Provider Services and Plan Administrator are authorized to sign the report.
6. The quarterly report shall have separate categories of grievances for Commercial enrollees, Medicare enrollees, and Medi-Cal enrollees (if applicable).
7. For each of the complaints identified in the quarterly report VCHCP shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

DELEGATION

VCHCP delegates the behavioral health Grievance and Appeals process to OptumHealthcare Behavioral Solutions of California. VCHP provides the required delegation oversight of this function. See the Umbrella Policy-Delegation Oversight Plan and the OptumHealthcare Delegation Agreement for complete details.

APPENDIX

A. Attachments:

Related Policies:

1. Members' Rights and Responsibilities (Attachment I)
2. Accessibility of Services (Quality Policy)
3. Independent Medical Review (IMR) Process (See UM Policy)

4. Policy on Potential Quality Issues (PQI) (See QA Policy)
5. Utilization Management Policy for Appeals (See UM Policy)
6. Policy for Retrospective Review of Member/Provider Inquiries
7. Confidentiality of Medical Information Policy (See QA Program Description)
8. On-Call Duty Roster Example
9. UM Appeal System Controls Policy

B. References:

1. Health & Safety Code Section 1374, et seq
2. Advisory No. 3 RE 1999 Legislation
3. Revised 10/06/03 Document OP 08-00, Title 10, emergency regulations
4. Health and Safety Code 1368(a)(1), 1368(a)(2),1368(c), 1368.01(a), 1368(a)(4), 1370.2, 1374.30(m),1368.01(b), 1368.02(b), 1374.30(i), 1368.1(a), 1374.30(a), 1374.30(e), 1374.30(h), 1374.30(l)
5. 28 CCR 1300.68(a), 1300.68(a)(4)(B), 1300.68(b),1300.68 (b)(1), 1300.68(b)(2), 1300.68(b)(3), 1300.68(b)(4), 1300.68(b)(5), 1300.68(b)(6), 1300.68(b)(7), 1300.68(b)(9), 1300.68(c),1300.68(d)(1), 1300.68(d)(2), 1300.68(d)(3), 1300.68(d)(4), 1300.68(d)(5), 1300.68(d)(6), 1300.68(d)(7), 1300.68(d)(8), 1300.68(e), 1300.68(f)(1), 1300.68.01(a)-(c), 1300.68(b)(10), 1370.4(a)-(e), 1370.74.30(a)-(l)&(n)

C. Effective Date: 2009

D. Approvals:

COMMITTEE	DATE
Quality Assurance Committee (QAC)	2009, 2011, 2012, 2013, 2014, 2015
Quality Assurance Committee (QAC)	2/23/2016, 2/28/2017, 2/27/2018
Quality Assurance Committee (QAC)	5/29/2018, 11/27/2018, 2/26/2019
Quality Assurance Committee (QAC)	02/25/2020, 11/24/2020, 2/23/2021
Quality Assurance Committee (QAC)	02/22/2022
Quality Assurance Committee (QAC)	02/07/2023
Quality Assurance Committee (QAC)	11/28/2023
Quality Assurance Committee (QAC)	02/27/2024
Quality Assurance Committee (QAC)	05/28/2024
Quality Assurance Committee (QAC)	11/26/2024
Quality Assurance Committee (QAC)	02/25/2025

VENTURA COUNTY
HEALTH CARE PLAN

ATTACHMENT I

STANDARDS FOR MEMBERS' RIGHTS AND RESPONSIBILITIES

Ventura County Health Care Plan (VCHCP) is committed to maintaining a mutually respectful relationship with its Members that promotes effective health care. Standards for Members Rights and Responsibilities are as follows:

1. Members have a right to receive information about VCHCP, its services, its Practitioners and Providers, and Members' Rights and Responsibilities.
2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.
3. Members have a right to participate with Practitioners and Providers in decision making regarding their health care.
4. Members have a right to a candid discussion of treatment alternatives with their Practitioner and Provider regardless of the cost or benefit coverage of the Ventura County Health Care Plan.
5. Members have a right to make recommendations regarding VCHCP's Member Rights and Responsibility policy.
6. Members have a right to voice complaints or appeals about VCHCP or the care provided.
7. Members have a responsibility to provide, to the extent possible, information that VCHCP and its Practitioners and Providers need in order to care for them.
8. Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Practitioners and Providers.
9. Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

VENTURA COUNTY
HEALTH CARE PLAN

CHANGE HISTORY

Revision Date	Content Revised?	CONTRIBUTORS	REVIEW/REVISION NOTES
01/25/2017	No	Christina Turner	Updated template to include Change History Page.
01/27/2017	Yes	Christina Turner Faustine DeLaCruz	Removed QAC and added MPEC to review process and removed Provider Dispute Resolution Mechanism (PDRM) from the Related Policies section. Updated Related Policy section for QA and UM
12/29/2017	No	Christina Turner	Updated dates to show 2018, and minor formatting changes. Also added On-Call Duty Roster to Attachment List.
04/12/2018	Yes	Christina Turner	Removed reference to the Treatment Authorization Request(TAR); Authorization Process & Timeline Standard (See UM Policy) and added a reference to the Exempt Grievance Desk Procedure.
08/24/2018	Yes	Christina Turner	Removed reference to 14-day extension if appeal not resolved within 30 days. Also updated the section Expedited Review of Urgent Grievances to include immediate notification wording.
01/29/2019	Yes	Christina Turner	Updated dates to show 2019 and added additional information under the Appeal Rights section to include the DMHC required language included on the appeal denial letters.
06/27/2019	No	Christina Turner	Updated the name and contact information for the Director of Member and Provider Services and Medical Director.
11/20/2019	Yes	Christina Turner	Added new section for grievances specific to terminations for cancellations, rescissions, and non-renewals of an enrollment or subscription.
12/13/2019	No	Christina Turner	Updated dates for 2020.
01/22/2020	Yes	Christina Turner	Updated the DMHC contact information per the APL dated 1/15/2020.
03/03/2020	Yes	Christina Turner	Updated the section specific to terminations for cancellations, rescissions, and non-renewals of an enrollment or subscription, per feedback received from the DMHC.
06/25/2020	Yes	Christina Turner	Updated the section specific to terminations for cancellations, rescissions, and non-renewals of an enrollment or subscription, per additional feedback received from the DMHC.
09/11/2020	No	Christina Woods	Updated last name for Director of Member and Provider Services from Turner to Woods. Also added information regarding the Annual and New Member Packets.
12/02/2020	No	Christina Woods	Updated dates for 2021
12/16/2021	No	Christina Woods	Updated dates for 2022
01/24/2022	Yes	Christina Woods	Added language regarding member appeals submitted by providers specific to Rx denials.
12/29/2022	No	Christina Woods	Updated dates for 2023
7/20/2023	No	Christina Woods	Added effective date and clarified “calendar days” where appropriate.
10/26/2023	Yes	Christina Woods	Updated the DMHC disclaimer to uncapitalize the word department in three instances and add a missing comma.
11/27/2023	Yes	Christina Woods	Updated to meet NCQA requirements.
12/13/2023	Yes	Christina Woods	Additional updates for NCQA compliance and added reference to UM Appeal System Controls policy.
12/20/2023	No	Christina Woods	Made minor formatting updates to the DMHC Disclaimer.
02/02/2024	No	Christina Woods	Updated the DMHC Disclaimer to bold the Plan’s TDD lines, per DMHC.

VENTURA COUNTY
HEALTH CARE PLAN

Revision Date	Content Revised?	CONTRIBUTORS	REVIEW/REVISION NOTES
05/03/2024	Yes	Christina Woods	Added language that members are advised of their appeal rights in the notification letters.
10/07/2024	Yes	Christina Woods	Added additional language to meet NCQA requirement ME7A3.
01/08/2025	Yes	Christina Woods	Added information to affirm that enrollees can submit grievances for failure to provide TGI health care.
01/29/2025	Yes	Christina Woods	Added that QOC complaints are forwarded to the Medical Director for review to the Exempt Grievance section, per the Follow-Up Report for the 2021 Routine Survey received on 1/28/2025.