UTILIZATION MANAGEMENT	ASPIREHEALTHPLAN	**Effective Date** 01/01/2021	
		Policy # AHP ASO OP005	
	FORWARDING GRIEVANCES, COMPLAINTS AND APPEALS TO HEALTH PLAN	**Review Date** 3/20/2024	**Applicable to:** ☐ Medicare Advantage ☐ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Kellie Verdugo, RN, Director of Utilization Management	

1.0 PURPOSE

1.1 Aspire Health Plan (AHP) recognizes that members have the right to voice concerns without fear of discrimination or reprisal and to have these concerns reviewed and addressed in a timely manner.

1.2 As a Restricted Knox-Keene licensed health plan, AHP is not delegated for handing Grievances and Appeals (as defined below); however, AHP promptly identifies and forwards all Complaints, Grievances and Appeals from Members or their representatives to the appropriate department or entity for processing and resolution. The purpose of this policy is to describe the process for notifying a Full-Service Plan Partner when their Members voice Complaints, Grievances and/or Appeals to AHP.

2.0 POLICY

2.1 AHP will forward all Complaints, Grievances and Appeals within the timeframes prescribed by the applicable State, federal, or contract requirements. AHP will forward Complaints, Grievances, and Appeals using the method outlined in the contract with or other documentation from the Full-Service Plan Partner.

2.2 Anthem Blue Cross of California ("Anthem" or "ABC") HMO: Per Anthem's direction,

2.2.1 AHP will forward (by fax) all ***standard*** written (including electronic) member Grievances, Complaints, or requests for Appeals to Anthem Blue Cross within one (1) business day of receiving the Complaint, Grievance, or request for Appeal to FAX 1-877-551-6183. See below for more information regarding record retention requirements.

2.2.2 AHP will forward (by fax) all ***urgent*** written (including electronic) member Grievances within one (1) hour of receiving the Grievance to FAX 1-855-

211-3699. See below for more information regarding record retention requirements.

2.2.3 If AHP receives a verbal complaint, grievance, or request for appeal, AHP will provide the caller with information regarding how to file their Grievance on the Anthem website, the phone number for how to contact Anthem's Appeals and Grievances Department, and be offered a warm transfer to the designated Anthem contact at 1-800-365-0609 (TTY/TDD: 1-866-333-4823). See below for more information regarding record retention requirements.

2.3 Blue Shield of California: Per Blue Shield's direction

2.3.1 AHP will promptly notify Blue Shield of any appeals or grievances asserted by a Member or Plan Provider.

2.3.2 AHP will cooperate with Blue Shield in identifying, processing, and resolving all Member and Plan Provider grievances, appeals and other complaints in accordance with Blue Shield's complaint/grievance process and time limits set forth in the Provider Manual and such time limits as required by state and/or federal law.

2.3.3 AHP will comply with Blue Shield's resolution of any such complaints or grievances and any specific findings, conclusions or orders of the DMHC.

3.0 Member and Provider Adverse Determination and Modification Notices

3.1 Member and provider adverse determination and modification notices are required to include the following content:

3.1.1 Department of Managed Health Care Complaint Process:

"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 **<(800) 393-6130 or TTY/TDD line 711- Blue Shield> <1-800-365-0609 or TTY/TDD users may call 1-866-333-4823 – Anthem>** 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."

3.1.2 Independent Medical Review through the DMHC – voluntary appeal procedure:

"Members have the right to request an IMR through the DMHC, as indicated in the above paragraph. Members may apply for an IMR if A) the member's provider has recommended a healthcare service as medically necessary, or B) the member has received urgent care or emergency services that a provider determined was medically necessary, or C) in the absence of a provider recommendation or the receipt of urgent care or emergency services, the member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review. Expedited external medical review can occur concurrently with the internal appeals process for urgent care. Members can contact the DMHC directly."

3.1.3 Employee Retirement Income Security Act (ERISA) notification:

"You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your Health Plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employers benefit plan administrator to determine if your employer's benefit plan is governed by ERISA. Additionally, you and your Health Plan may have other voluntary alternative dispute resolution options, such as mediation.

3.1.4 Diagnosis/Treatment Codes:

"Member can obtain, upon request, a written statement describing the availability of diagnosis and treatment codes and their corresponding meaning."

3.1.5 Consumer Resources:

"Other resources to help you: Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California. California Department of Managed Health Care Help Center: Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891, www.dmhc.ca.gov"

4.0 DEFINITIONS

4.1 An "Appeal" is the procedures that deal with the review of adverse determinations made by AHP regarding health care services or benefits the Member believes he or she is entitled to receive, including a delay, denial, or modification in providing, arranging for, or approving the health care services or drug coverage (when a delay

would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug.

4.2 A “Complaint” is the same as a “Grievance.”

4.3 A “Complainant” is the same as a “Grievant” and means the person who filed the Grievance including the enrollee, or other individual with authority to act on behalf of the enrollee, including but not limited to the member’s provider.

4.4 A “Grievance” means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a Grievance.

4.5 A “Member” (who may also be known by Anthem as a “Covered Individual”) is the patient who receives services.

4.6 A “Legal Representative” is defined as an individual or individual(s) that exercise healthcare power of attorney on behalf of the Member.

5.0 PROCEDURE

5.1 Members Informed of Procedure

5.1.1 The grievances, complaints and appeals resolution process for Members and/or their representatives is outlined in the Member’s Evidence of Coverage (“EOC”), as provided by the Full-Service Plan Partner. As a Restricted Knox-Keene licensee, AHP does not furnish member EOCs.

5.2 Receipt of a Grievance, Complaint of Request for Appeal

5.2.1 In performing the work delegated by the Full-Service Plan Partner, AHP may receive a complaint, appeal or grievance from a member directly.

5.2.2 The AHP department(s) will route any incoming complaints, grievances or appeals to the AHP A & G Department.

5.2.3 Responsibility for the complaint, grievance and appeal forwarding process lies with AHP Appeals & Grievances Department.

5.3 Response to a Grievance, Complaint or Request for Appeal

5.3.1 Anthem HMO: The Anthem Grievances and Appeals department (G&A) is responsible for documenting, investigating, resolving, and responding to all medical, behavioral health, benefit, and administrative grievances and appeals.

5.3.1.1 All complaints, grievances and appeals received by AHP are forwarded to the Anthem Grievances and Appeal department.

5.3.1.2 Upon receipt of a written Member complaint, grievance or request for appeal, AHP will forward (by fax) the written information within one business day to the designated health plan contact at 1-818-234-1089.

5.3.1.3 Upon receipt of a verbal Member-related complaint, grievance or request for appeal, the caller will be transferred to the designated Anthem contact at 1-800- 365-0609 (TTY/TDD 1-866-333-4823)

5.3.1.4 The information provided by AHP to Anthem will include:

5.3.1.4.1 Date of receipt

5.3.1.4.2 Method of receipt (written or verbal)

5.3.1.4.3 Party received from (member, member representative, provider)

5.3.1.4.4 Detail of the complaint(s), grievance(s) and/or appeal(s)

5.3.1.5 If the grievance or complaint alleges release of restricted information during the AHP UM process, the AHP Privacy Officer is also notified and the investigation is handled by the Privacy Officer in addition to the grievance or complaint being forwarded to Anthem.

5.3.1.6 Grievance, Complaint or Request for Appeal Recordkeeping

5.3.1.6.1 AHP will maintain electronic copies of the complaints, grievances or requests for appeal in a grievance log for five (5) years or in compliance with other applicable law and AHP's record retention policies.

5.3.1.7 Anthem HMO: While complaints, appeals and grievances are forwarded to Anthem immediately upon receipt, AHP will make the grievance log maintained by the Health Plan available to Anthem on a monthly basis, to assist Anthem in the reconciliation process.

5.3.1.7.1 AHP will, at the request of Anthem, assist Anthem in the handling of Complaints, Grievances, and Appeals according to Anthem's Appeals and Grievances policies and procedures.

5.3.1.7.2 AHP will comply with all final Grievance and Appeal determinations made by Anthem and/or the Department of Managed Health Care.

5.3.2 Blue Shield of California: The member, member representative, or an attorney or provider on the member's behalf, may file a grievance by contacting Blue Shield's Customer Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com.

5.3.2.1 Blue Shield researches and investigates all grievances and, as appropriate,

5.3.2.2 The Blue Shield Medical Director may review a grievance.

5.3.2.3 For commercial members, call (800) 541-6652.

6.0 TRAINING

6.1 Training regarding the appropriate handling of Grievances and Appeals for Member-facing employees will occur within ninety (90) days of hire, annually, upon updates to the policy, and as otherwise needed.

7.0 REVIEW PERIOD

7.1 Annually.

8.0 REGULATORY REQUIREMENTS AND REFERENCES

8.1 2022 Anthem HMO Manual, Covered Individual Grievance and Appeals Process

8.2 2022 Blue Shield of California HMO IPA/Medical Group Manual CA Health and Safety

8.3 Code Sections 1368

8.4 28 CCR 1300.68

9.0 POLICY VIOLATION

9.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.