| Health Care Agency<br>Behavioral Health Services<br>Policies and Procedures | Section Name:<br>Sub Section:<br>Section Number:<br>Policy Status: | Medi-Cal Managed Care<br>Beneficiary Rights<br>09.02.01<br>☒New ☐Revised |
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| Director of Operations<br>Behavioral Health Services | Signature on File | 3/27/18 |

**SUBJECT:** Beneficiary Problem Resolution and Grievance Process

**PURPOSE:**

To outline the process for responding to and resolving grievances of all Medi-Cal beneficiaries receiving services through Orange County Behavioral Health Services (BHS) Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) County-operated and County-contracted clinics and Inpatient Treatment Programs.

**POLICY:**

It is the policy of BHS that at every step of these procedures, staff shall maintain the confidentiality of beneficiaries, consistent with other policies related to State and Federal confidentiality and privacy regulations.

BHS County-operated and County-contracted clinic and Inpatient Treatment Program staff shall strive for the resolution of grievances at the point of service whenever possible. A uniform documentation process shall be followed to track the number, type, and resolution of all grievances.

**SCOPE:**

These procedures apply to all MHP and DMC-ODS beneficiaries. It is not necessary that the beneficiary be receiving MHP and DMC-ODS services within BHS County-operated and County-contracted clinics at the time the grievance is submitted.

**REFERENCES:**

BHS P&P 09.02.02 Beneficiary Appeal of Actions Process

BHS P&P 02.06.02 Informing Materials for Behavioral Health Services Consumers and Intake/Advisement Checklist

**FORMS:**

Grievance and Appeal Form F346-706 DTP318

State Fair Hearing Request Form F346-742 DTP1115

Authorization to Use and Disclose Protected Health Information

Notification of Adverse Benefit Determination (NOABD) - Delay in Grievance/Appeal Processing

Your Rights Under Medi-Cal Notice

Notification of Grievance Resolution (NGR)

Non-Discrimination Notice

Language Assistance Notice

Acknowledgement of Receipt

**DEFINITIONS:**

Adverse benefit determination:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for 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, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeals - Appeals are defined as a request for a review of an "adverse benefit determination" (see above for definition of adverse benefit determination). Appeals processes are outlined in the BHS Policy and Procedure 09.02.02 Beneficiary Appeal of Action Process.

Authority and Quality Improvement Services (AQIS) – Is an administrative unit providing oversight and coordination of quality improvement and compliance activities across the Divisions of BHS.

Beneficiary – A person with Medi-Cal coverage. For the purposes of this policy and procedure, "beneficiary" includes a parent, guardian, conservator, or other authorized representative, unless otherwise specified.

Days - Defined as calendar days unless otherwise specified.

Enrollee – A beneficiary receiving services under the MHP or DMC-ODS.

Grievance - A beneficiary's expressed dissatisfaction to the MHP or DMC-ODS or any provider (including contract providers) about any matter having to do with the provision of Medi-Cal services, other than a matter covered by an Appeal. This includes, but is not limited to: rudeness or attitude of staff, location of services, physical plant, access or availability. The expressed dissatisfaction is defined as a grievance, whether or not it is submitted in writing, whether or not the beneficiary states that they wish to file a grievance, even if the beneficiary explicitly states they do not want to file a grievance and whether or not the beneficiary uses the term "grievance".

Notice of Adverse Benefit Determination (NOABD) - Form used to notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. There are multiple versions of this form, to be used depending on the situation.

Patients' Rights Advocacy Services (PRAS) – A department within BHS with multiple responsibilities, including providing assistance, advice and advocacy services to beneficiaries and their family members who have filed a grievance or requested a State Fair Hearing.

Participating Inpatient Health Plan (PIHP) – The State Department of Health Care Services (DHCS) has notified counties that the county MHP and DMC-ODS are considered PIHPs for purposes of CFR, Title 42, Chapter IV, § 438.

Provider Representative – The individual assigned at each clinic and treatment site to educate and assist beneficiaries and family members with grievances. The Provider Representative is the person designated to provide information to the beneficiary about the status of a grievance upon request.

Resolved – Means that the MHP has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.

Working Day – A working day is defined as Monday through Friday, 8:00am-5:00pm, excluding County holidays.

**PROCEDURES:**

I. Grievance information shall be made available to beneficiaries without having to request it verbally or in writing, in all clinics and inpatient treatment programs, and placed in a conspicuous location for beneficiaries.

II. The beneficiary shall be informed of their right to access PRAS at any time before, during or after the Grievance Process for information, assistance and representation. The Patients' Rights Advocate, upon the beneficiary's or parent/guardian/conservator's

request, shall provide information and assistance regarding legal rights and may represent the beneficiary through the grievance process.

III. The beneficiary may choose an authorized Representative to act on his/her behalf. This person can be a family member, significant other or other person of his/her choice. The beneficiary's legal Representative may use the grievance process on the beneficiary's behalf. The beneficiary shall provide written confirmation of the authorization of a Representative by completing an Authorization to Use and Disclose Protected Health Information (PHI). The beneficiary will complete all necessary sections and document the representative's name, address and phone number and indicate under Part 4 Other: "Acting as representative for the grievance process."

IV. Staff at all levels shall assist the beneficiaries in completing the forms and other procedural steps related to a grievance. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

V. All BHS County-operated and County-contracted clinics and inpatient treatment programs shall have a mechanism for beneficiaries to resolve grievances. Clinic staff shall inform beneficiaries of their rights and assist them in problem resolution through the grievance process. A grievance may be filed at any time.

VI. No consumer shall be subject to discrimination or any other penalty for filing a grievance.

VII. A beneficiary may file a grievance at any time and a grievance may be filed orally or in writing.

VIII. Grievance Process–Outpatient Clinic and Inpatient Treatment Program Responsibilities:

A. The Service Chief, Program Director or Inpatient Program Director shall ensure that the following materials are located in a conspicuous location in the clinic or inpatient unit. Materials shall be in English and in all of the threshold languages. The location of the materials shall be such that the beneficiary does not have to make a verbal or written request to anyone for the materials:

1. Grievance or Appeal form (which includes the phone number for filing a grievance verbally).

2. Pre-addressed envelopes for submitting the form.

3. Consumer Grievance and Appeal Process poster.

B. A beneficiary is encouraged to first direct the grievance to the appropriate Plan Coordinator, therapist, outpatient clinic Service Chief, Program Director, Inpatient Program Director or Provider Representative. However, the beneficiary may use the grievance process whether or not these steps have been taken.

C. Staff are to make all reasonable efforts to address the grievance at the local level to the satisfaction of the beneficiary. If staff is unable to resolve the grievance to

the satisfaction of the beneficiary by the end of the business day following the expression of dissatisfaction, or if the beneficiary chooses not to attempt to resolve the grievance at the local level, then the grievance will be processed by Authority and Quality Improvement Services.

D. Regardless of the outcome of the attempts to resolve the grievance, the clinic staff shall log the grievance and the resolution.

E. If the grievance was not resolved to the beneficiary's satisfaction, the staff shall notify Authority and Quality Improvement Services.

IX. Grievance Process – Authority and Quality Improvement Services (AQIS)

A. AQIS shall process all grievances, except those at provider sites which are resolved to the satisfaction of the beneficiary, by the end of the business day following the expression of dissatisfaction.

B. If a grievance is received by phone, the AQIS Grievance Representative shall complete a grievance form.

C. AQIS Grievance Representative shall complete and mail a Grievance Acknowledgement to the beneficiary within 5 days from the time the grievance is received.

1. The acknowledgement letter shall include notification of the opportunity to provide, in person or in writing, evidence and testimony and to make legal and factual arguments and of the limited time available to do this.

D. AQIS Grievance Representative shall log receipt of the grievance on the day it is received. All sections of the grievance log shall be completed at this time, with the exception of the resolution section.

E. AQIS Grievance Representative will give the grievance form and/or grievance letter along with the Grievance Acknowledgement to the designated AQIS Office Support staff.

F. Designated AQIS Office Support staff will scan the grievance form and/or letter along with the Grievance Acknowledgement into the beneficiary's electronic grievance file.

G. Designated AQIS Office Support will notify the designated Investigating Representative by emailing the link where the grievance is located and placing a scan of the email in the beneficiary's electronic grievance file.

H. Grievances will be investigated by a designated Investigating Representative. The Investigating Representative will have the appropriate clinical expertise to treat the beneficiary's condition and in addition shall not have been involved in any previous

level of review or decision-making, and shall not be the subordinate of any individual who was involved in a previous level of review or decision making.

I. The Investigating Representative will research the grievance and prepare the decision and/or action on the grievance. Within the parameters of confidentiality, all relevant information, resources and involvement of others shall be utilized to resolve the grievance within 90 days, unless the beneficiary requests additional time or agrees to a continuance. Decision makers on grievances shall take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

1. Exceptions to the 90 day timeframe.

a) If the beneficiary requests an extension, or if the Investigating Representative determines that there is a need for additional information and that the delay is in the beneficiary's interest, this timeframe may be extended by up to 14 calendar days.

i) If the Investigating Representative extends the timeframe not at the beneficiary's request, the beneficiary shall be given prompt oral notice and written notice of the extension and the reasons for the extension within 2 calendar days of the decision to extend. The written notice shall inform the beneficiary of the right to file a grievance if he/she disagrees with the decision to extend the timeframe.

b) If the grievance is related to the MHP or DMC-ODS decision to extend the timeframe for making an authorization decision, then the timeframe for resolution is 30 days.

J. If the grievance has not been resolved within the required timeframe, then the Investigating Representative shall:

1. Make reasonable effort to give the beneficiary prompt oral notice of the delay, and document the attempt and outcome in the beneficiary's file.

2. Prepare a Notice of Adverse Benefit Determination - Delay (NOABD-D) to the beneficiary. Give the completed NOABD, the Your Rights Under Medi-Cal Notice, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS Support Staff, to scan into the beneficiary's grievance file and mail to the beneficiary.

3. These documents will advise the beneficiary of the right to request a fair hearing. The NOABD shall be provided on the date that the timeframe expires.

K. Upon resolution of the grievance, the Investigating Representative shall complete a Notice of Grievance Resolution (NGR) and give the NGR, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS Office Support staff to scan into the beneficiary's grievance file and mail to the beneficiary and designated parties using Delivery Confirmation.

L. Upon receipt of the Delivery Confirmation, the AQIS Office Support Staff shall scan it into the beneficiary's grievance file.

M. If there is no address for the beneficiary, the e-filed letter will remain stored in the designated grievance folder.