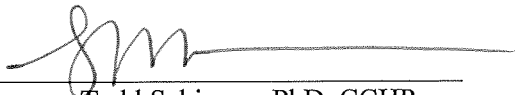


County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-19
	Next Review Date: February, 2026
POLICY:	Date Approved:
<u>CONSUMER GRIEVANCE AND APPEAL RESOLUTION</u>	Date Reviewed/Approved: February 9, 2023,
SUPERSEDES – PP 214-04, 210-10, 209-08, 204-08 & 99-04	By:  Todd Schirmer, PhD, CCHP Director of Behavioral Health and Recovery Services

POLICY: CONSUMER GRIEVANCE AND APPEAL RESOLUTION

I. PURPOSE:

The purpose of this policy is to inform staff of the established procedures for the Grievance and Appeal Resolution process and to ensure that Marin Behavioral Health & Recovery Services (BHRS) complies with current Department of Health Care Services (DHCS)/BHRS contract, State and Federal Regulations. Marin Behavioral Health & Recovery Services is a designated Mental Health Plan (MHP).

II. REFERENCES:

- Title 42 Code of Federal Regulations, Subpart F §438.400, 402,404,406,408,410,414, & 416
- Title 9, California Code of Regulations, Chapter 11, §1810.200 & 203.5 §1850.206, 207 & 208
- MHP Contract, Ex. A, Att. 11, sec. 3(f)(3)(a-b), Att. 12, sec 4(A)(1)
- Welf. & Inst. Code § 14727(a)(4-5.)
- DMC-ODS Intergovernmental Agreement, Exhibit A, Attachment I
- DMC-ODS Standard Terms and Conditions
- DHCS MHSUDS IN No: 18-010E

III. POLICY:

Marin Behavioral Health & Recovery Services makes every reasonable effort to meet consumers' needs. Consumer satisfaction with a particular provider or provider organization and with the treatment received is an important indicator of quality. Consumers will be advised of the Consumer Grievance Resolution process and given the opportunity to resolve dissatisfaction about any matter or concern that she or he may have at any time.

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The objectives of this policy are as follows:

1. Ensure that all consumers of Specialty Mental Health Services (SMHS) and Drug/Medi-Cal Organized Delivery System (DMC-ODS) substance use services receive written information concerning the Grievance Resolution process.
2. Provide the process for resolution of grievances, appeals and expedited appeals.
3. Ensure that all providers are aware of and comply with the Grievance Resolution processes.
4. Ensure that BHRS monitors the problem resolution process and provides a Quality Improvement feedback loop to improve the quality of services provided to recipients of Specialty Mental Health Services and DMC-ODS services in Marin County

IV. AUTHORITY/RESPONSIBILITY:

Quality Management Program
 Division Directors
 Program Managers/Supervisors
 Behavioral Health & Recovery Services Providers
 Patient Rights Advocate

Definitions:

- A. A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness or a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the Plan to make authorization decision. There is no distinction between an informal and formal grievance. A complaint is the same as a grievance. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Any consumer may submit a grievance orally or in writing.
- B. An Adverse Benefit Determination is defined to mean any of the following actions taken by BHRS:
 - a. 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;
 - b. The reduction, suspension, or termination of a previously authorized service;

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- c. The denial, in whole or in part, of payment for a service.
 - d. The failure to provide services in a timely manner.
 - e. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
 - f. The denial of a beneficiary's request to dispute financial liability.
- C, An Appeal is a review by BHRS of an Adverse Benefit Determination.

V. **PROCEDURES:**

A. Consumer Awareness of Grievance Resolution Process

- a. Consumers are notified about the grievance, appeal and expedited appeal procedures, the availability of State Fair Hearings and advocacy services upon admission. Consumers are notified of their right to request and obtain the "Beneficiary Booklet" and provider list at least once a year and thereafter upon request.
- b. Grievance and Appeal forms and information are available in English and Spanish, and in 18 pt font at each BHRS clinic site and contract provider site.
- c. Pre-paid postage mailers are available in waiting areas of BHRS clinics and contract provider sites.
- d. The above information is available for those consumers who are in residential treatment programs, such as Institutes of Mental Disease (IMD), Skilled Nursing Facilities (SNF), Licensed Board and Care Homes, and other sites where beneficiaries may obtain mental health and substance use disorder treatment services.
- e. Notices explaining the grievance, appeal, and expedited appeal process procedures are posted at BHRS provider and contractor sites to ensure that the information is readily available to both beneficiaries, and the provider staff. The posted notice shall also explain the availability of State Fair Hearings after exhaustion of an appeal or expedited appeal process.
- f. Information about the Grievance and Appeal Process is available in the BHRS "Member Handbook", DMC-ODS "Beneficiary Booklet" and the "Medi-Cal Beneficiary Guide to Mental Health Services", in English and Spanish.

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B. Grievance Resolution Process

When an employee of Behavioral Health & Recovery Services or a contracted provider learns of a consumer's dissatisfaction with services, providers, or any matter other than an Adverse Benefit Determination, the consumer will be notified of the option to file a grievance with BHRS. A complaint is the same as a formal grievance. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance.

- a. The consumer can fill out the Grievance/Appeal form and mail it to the BHRS Quality Management Unit at: 20 N. San Pedro Rd., , San Rafael, CA 94903 using the pre-paid postage mailer or may file the grievance orally in person, or by phone on the BHRS Access line at 1-888-818-1115, or the BHRS Grievance Line at (415) 473-6413.
- b. The designated BHRS Quality Management staff logs the grievance within one working day of receipt.
- c. The grievance and appeal log will record the following information:
 - (1) Name of grievant/authorized representative;
 - (2) Date grievance, appeal, or expedited appeal is received;
 - (3) Date acknowledgement is mailed;
 - (4) Nature of grievance;
 - (5) Final disposition of grievance, or reason why final disposition is/was not made within 90 calendar days from receipt of grievance;
 - (6) Date final disposition is made;
 - (7) Date final disposition is mailed to grievant/authorized representative;
 - (8) Date copy of final disposition is mailed to provider, if provider is involved in the grievance.
- d. Receipt of grievance will be acknowledged to beneficiary in writing within five calendar days.
- e. Grievances must be resolved within ninety (90) calendar days from the date the grievance is filed.
- f. The timeframe for resolving grievances related to disputes of BHRS' decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days.

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- g. The timeframe can be extended for up to fourteen (14) calendar days if the beneficiary requests an extension, or if BHRS determines that there is a need for additional information and that the delay is in the beneficiary's best interests. If BHRS extends the timeframes, BHRS shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing and inform the beneficiary of the right to file a grievance if they disagree with that decision and to resolve the grievance no later than the date the extension expires.
- h. The beneficiary may authorize another person to act on his/her behalf.
- i. Upon request, the beneficiary may identify a staff person or other individual to assist with the grievance and appeal process and/or provide information regarding the status of the grievance or appeal. If the individual identified is the person providing mental health services or substance use disorder treatment services to the beneficiary requesting assistance, BHRS shall identify another individual to assist the beneficiary with the grievance process.
- j. The beneficiary will not be subject to discrimination or any other penalty for filing a grievance, appeal or expedited appeal. The MHP shall provide continuation of specialty mental health services pending a fair hearing in accordance with 9 CCR§ 1850.215 (b).
- k. Individuals involved in any previous review or decision-making on the issue(s) presented in a problem resolution process shall not participate in making the decision on the grievance, appeal or expedited appeal pursuant to 42 CFR 438.406(a)(3)(i).
- l. If the grievance is about a clinical issue, the BHRS decision maker must be a health care professional with the appropriate clinical expertise in treating the consumer's condition.
- m. Designated BHRS Quality Management staff must notify the consumer or representative in writing of the grievance decision using Notice of Grievance Resolution (NGR) or document the efforts to notify the consumer if she/he could not be contacted.
- n. Grievances received over the telephone or in-person by BHRS, or a network provider, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgement and disposition letter.

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Discrimination Grievances

BHRS shall provide information to all beneficiaries, prospective beneficiaries, and member of the public on how to file a Discrimination Grievance with:

- a) BHRS and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
- b) The United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age or disability.

BHRS shall not require a beneficiary to file a Discrimination Grievance with BHRS before filing the complaint directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

BHRS shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with federal or state nondiscrimination law.

BHRS shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints.

Within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, BHRS must submit the following information regarding the complaint to the DHCS Office of Civil Rights (see California Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B):

- a. The original complaint.
- b. The provider’s or other accused party’s response to the complaint.
- c. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of BHRS.
- d. Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
- e. All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgement letter and resolution letter sent to the beneficiary.

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- f. The results of BHRS investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

C. Adverse Benefit Determinations

Beneficiaries must receive a written Notice of Adverse Benefit Determination (NOABD) when BHRS makes any adverse benefit determination. BHRS must give beneficiaries time and adequate notice of an adverse benefit determination in writing. The NOABD must explain all of the following:

- a. The adverse benefit determination BHRS has made or intends to make;
- b. A clear and concise explanation for the reason(s) for the decision. For determinations based on medically necessity criteria, the notice must include the clinical reasons for the decision. BHRS shall explicitly state why the beneficiary's condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria;
- c. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
- d. The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

- 1. NOABD "Your Rights" Attachment

The "Your Rights" attachment informs beneficiaries of critical appeal and State hearing rights and appropriate form must be sent to beneficiaries with each NOABD or Notice of Appeal Resolution (NAR.).

D. Standard Appeal Process for Medi-Cal Beneficiaries

- a. Only consumers who are Medi-Cal beneficiaries may submit a request to appeal an Adverse Benefit Determination.
- b. BHRS shall only have one level of appeal for beneficiaries.
- c. The Medi-Cal beneficiary files an appeal orally or in writing with the BHRS Quality Management Unit requesting review of

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an Adverse Benefit Determination. The appeal must be filed within sixty (60) calendar days of the Adverse Benefit Determination.

- d. BHRS must continue the beneficiary's benefits if all of the following occur:
 - i. The beneficiary files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice;
 - ii. The appeal involves the termination, suspension, or reduction of a previously authorized service;
 - iii. The services were ordered by an authorized provider;
 - iv. The period covered by the original authorization has not expired; and
 - v. The beneficiary files for continuation of benefits.
- e. The beneficiary, their representative, or the legal representative of a deceased beneficiary's estate may be included as parties to the appeal.
- f. An Adverse Benefit Determination occurs when BHRS: denies, or limits authorization of a requested service; reduces, suspends, terminates a previously authorized service; fails to provide a specialty mental health service within the timeframe for delivery as established by the MHP; fails to act within timeframes for resolution of grievances, appeals, or expedited appeals.
- g. Appeals must be resolved within thirty (30) calendar days of BHRS receipt of the appeal.
- h. If the appeal is oral, the beneficiary must follow up with a signed, written appeal. The date of the oral appeal starts the time frame.
- i. Designated BHRS Quality Management staff will log the appeal within one (1) working day of the date of receipt of the appeal.
- j. Designated BHRS Quality Management staff will acknowledge receipt of the appeal in writing to the beneficiary.
- k. Designated BHRS Quality Management staff must notify the beneficiary or authorized representative of the Notice of Appeal Resolution (NAR) and the NAR "Your Rights" attachment in writing within thirty (30) calendar days of receipt of the appeal. The notice must contain the following:
 - a. The results of the resolution and the date is was

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- completed.;
- b. The reasons for the determination, including criteria, clinical guidelines, or policies used in reaching the determination;
 - c. The beneficiary's right to a State Fair Hearing and the procedure for requesting a State Fair Hearing (if the appeal is not resolved wholly in favor of the beneficiary):
 - 1. The beneficiary's right to request benefits while the hearing is pending and the procedure for making this request; and
 - 2. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds BHRS adverse benefit determination.
 - 3. Beneficiary/authorized representative may file a request for a State Fair Hearing if not satisfied with the outcome of the appeal to:

State Hearing Division
California Department of Social Services
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2530

- d. The time frame for the appeal process may be extended by up to fourteen (14) days if the beneficiary requests an extension; or if BHRS determines that there is a need for additional information and that the delay is in the beneficiary's interest. If an extension is required, designated BHRS Quality Management staff will send notice to the consumer in writing.
- e. During the appeal process, a beneficiary may present evidence and arguments of fact or law, in person and/or in writing.
- f. During the appeal process, a beneficiary and/or his/her representative may examine the beneficiary's case file and any other documents or records considered before and during the appeal process, provided that there is no disclosure of the protected health information to any individual other than the beneficiary.

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E. Expedited Appeals for Medi-Cal Beneficiaries

- a. An oral or written request for an expedited review of an Adverse process could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. Oral expedited appeals **do not** have to be followed up in writing.
- b. Designated BHRS Quality Management staff logs the appeal within one (1) working day of receipt of the expedited appeal request and acknowledges receipt of any written expedited appeal in writing to the beneficiary.
- c. BHRS has the authority to decide if the request for an expedited appeal meets the criteria.
- d. No punitive action shall be taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.
- e. Beneficiaries shall be informed of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expediated appeal sufficiently in advance of the resolution timeframe for an expediated appeal.
- f. If the expedited appeal request is denied, designated BHRS Quality Management staff will provide the beneficiary with oral and written notice of the denial. The appeal then follows the standard appeal process.
- g. If the request is approved, the expedited appeal must be resolved and the affected parties must be notified of the decision orally and in writing no later than 72 hours after BHRS receives the expedited appeal request.

F. Language Assistance, Nondiscrimination Notice and Taglines

- a. Translation of Notices
 Written materials that are critical to obtaining services including, at a minimum, appeal and grievance notices, and denial and termination notices, which must be made available to beneficiaries in threshold languages and alternative formats.
- b. Nondiscrimination Notice and Language Assistance
 Taglines Federal regulations require BHRS to post nondiscrimination notice requirements and language assistance taglines n significant communication to beneficiaries. These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: NOABD, grievance acknowledgment letter, appeal acknowledgement letter, grievance resolution letter, and NAR.

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G. Quality Improvement Committee Monitoring

- a. Designated BHRS Quality Management staff will compile data and report: number of cases, types of issues, number of unresolved grievances, number of resolved grievances, number of appeals and the number of State Fair Hearings. The Quality Improvement Committee (QIC) will identify trends that surface in the annual reports and make recommendations for improvement.
- b. BHRS will submit an annual report to DHCS that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition.
- c. Designated BHRS Quality Management staff will track the Consumer Grievance and Appeal Resolution Process using the Grievance Log and will submit an annual report to the QIC for review.

