Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Problem Resolution 02.02.02 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Deputy Director Behavioral Health Services	Signature on File	2/14/2024

SUBJECT: Beneficiary/Client Problem Resolution, Grievance Process and Logging Procedures in Outpatient County and Contracted Clinics and Inpatient Treatment Programs

PURPOSE:

To outline the process for responding to and resolving concerns and grievances of all beneficiaries/clients (and parent/guardian/conservator as appropriate) receiving services through Orange County's Behavioral Health Services (BHS) 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/clients, consistent with other policies related to State and Federal confidentiality and privacy regulations.

BHS County and County Contracted clinic and Inpatient Treatment Program staff shall strive for the resolution of concerns 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 beneficiaries/clients and parent/guardian/conservator receiving services within BHS County and County contracted clinics. This includes mental health and substance use treatment services and Inpatient mental health treatment programs, including but not limited to services funded by Drug Medi-Cal Organized Delivery System (DMC-ODS), Mental Health Plan (MHP), Substance Use Prevention and Treatment Block Grant (SUBG), Tobacco Settlement Revenue (TSR) and county block grants. Students receiving educationally related services through an IEP shall route grievances through the IEP process. If the youth grievance is filed using the BHS grievance process, BHS staff will coordinate with Children and Youth Services (CYS) Administration.

REFERENCES:

BHS P&P 02.02.03 Beneficiary Appeal of Actions Process

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

Medi-Cal Mental Health Plan Contract with the Department of Health Care Services

FORMS:

Grievance and Appeal Form F346-706 DTP318

State Fair Hearing Request Form F346-742 DTP1115

Notice of Adverse Benefit Determination (NOABD) Delay in Grievance/Appeal Processing Acknowledgement of Grievance Letter

Non-Discrimination Notice

Notice of Grievance Resolution (NGR)

DEFINITIONS:

Adverse benefit determination is defined to mean any of the following actions taken by a Plan:

(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 Federal guidelines and State law.

(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 an enrollee'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 action).

Quality Management Services (QMS) – Is an administrative service area within BHS providing oversight and coordination of quality improvement and compliance activities across all Divisions of BHS.

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

Client – A person with no Medi-Cal coverage. For the purpose of this policy and procedure, "client" 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/client'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 and perceived discrimination. 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)- Written notification to the requesting provider and the enrollee 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.

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

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

Provider Representative – The individual assigned at each clinic and treatment site to educate and assist beneficiaries/clients 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 and DMC-ODS has reached a decision with respect to the beneficiary's/Client's grievance and has notified the beneficiary/client of the disposition.

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

PROCEDURES:

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

A. 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.

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

C. The beneficiary/client and/or parent/guardian/conservator shall be informed of their right to access the QMS Grievance Representative and/or PRAS at any time before, during or after the Grievance Process for information, assistance and representation.

D. The beneficiary/client and/or parent/guardian/conservator 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/client's legal Representative may use the grievance process on the beneficiary's behalf. The beneficiary/client and/or parent/guardian/conservator shall provide written confirmation of the authorization of a representative by completion of an Authorization to Use and Disclose Protected Health Information to that representative which documents that it is for the purpose of acting as the representative for the grievance process.

E. No beneficiary/client or parent/guardian/conservator shall be subject to discrimination or any other penalty for filing a grievance.

II. A beneficiary/client or parent/guardian/conservator may request assistance with a grievance from the QMS Grievance Representative and/or PRAS at any point in the process. The Patients' Rights Advocate, upon the beneficiary's/client's or parent/guardian/conservator's request, shall provide information and assistance regarding legal rights and may represent the consumer through the grievance process.

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

A. Beneficiary/client concerns may be brought to the attention of BHS in several different ways, in accordance with current regulations. A beneficiary/client or parent/guardian/conservator is encouraged to first direct concerns to the

appropriate Plan Coordinator, therapist, outpatient clinic Service Chief, Program Director, Inpatient Program Director or Provider Representative, but may use the grievance process whether or not these steps have been taken.

B. Staff are to make all reasonable efforts to address the concerns at the local level to the satisfaction of the beneficiary/client.

1. Regardless of the outcome of the attempts to resolve the concern, the treatment staff shall ask the beneficiary/client if he/she wishes to have the concern addressed as a grievance and shall inform the beneficiary/client of their rights and process for filing a grievance, including the location of grievance materials that are available in each service site without verbal or written request to anyone. The staff shall also offer the beneficiary/client assistance in filing the grievance if the beneficiary/client so desires. If the beneficiary/client indicates a desire to file a grievance without completing any paperwork, the staff shall complete the Grievance or Appeal form, putting that staff person's identifying information on the form in the section asking for identification of those filling out the form if they are not the beneficiary/client. The treating clinician shall not be the staff person who assists with completion of the grievance form, unless requested by the beneficiary/client. The staff person completing the form shall send it to QMS on day of the beneficiary's/client's indication that he/she wishes to file a grievance.

2. If the 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 QMS.

IV. 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/client does not have to make a verbal or written request to anyone for the materials:

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

B. Pre-addressed envelopes for submitting the form.

C. Beneficiary Grievance and Appeal Process poster.

D. Beneficiary Non Discrimination Notice

V. Grievance Process – Quality Management Services (QMS) Responsibilities when received by phone, mail, or fax:

A. Grievances may reach QMS in any of 3 primary ways:

1. A beneficiary/client may mail in a Grievance or Appeal Form.

2. A beneficiary/client may phone in a grievance.

3. A clinic may send in a Grievance or Appeal Form.

B. QMS Grievance Representative shall complete and mail a Grievance Acknowledgement Letter to the beneficiary/client within 5 calendar days from the date the grievance is received. The acknowledgement letter includes the date of receipt, name of representative to contact, telephone number of contact representative and address of either the MHP or DMC-ODS plan or Inpatient Treatment Program. The beneficiary will also receive the NAR Your Rights, Language Assistance Taglines and Beneficiary Non-discrimination Notice with the Acknowledgement Letter.

C. The beneficiary/client shall be notified 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. QMS Grievance Representative shall log receipt of the grievance within one business day from when it is received. All sections of the grievance log shall be completed including the date of the NGR.

E. QMS Grievance Representative will issue and mail out the acknowledgment letter.

F. Grievances will be investigated by the QMS Grievance Representative. The QMS Grievance Representative shall have the appropriate and clinical expertise to treat the beneficiary's/client'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.

VI. The QMS Grievance Representative shall 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/client or parent/guardian/conservator requests additional time or agrees to a continuance. The QMS Grievance Representative is responsible to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal. The 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. If the beneficiary/client requests an extension, or if the QMS Grievance Representative determine 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.

A. If the QMS Grievance Representative extends the timeframe, 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.

VII. QMS Grievance Representative shall create a resolution letter for the beneficiary/client within 90 days of receiving the grievance information from the beneficiary or representative (or within 104 days if an extension has been invoked as described above). If the grievance has not been resolved within the specified timeframe for a Medi-Cal beneficiary, then the QMS Grievance Representative shall provide a Notice of Adverse Benefit Determination-- Grievance and Appeal Timely Resolution notice (NOABD) to the beneficiary/client and shall make reasonable efforts to give the beneficiary prompt oral notice of the delay. This will advise the beneficiary of the right to request a fair hearing. The NOABD-Grievance and Appeal Timely Resolution notice shall be provided on the date that the timeframe expires.

VIII. The original resolution letter including the date the decision is sent to the beneficiary will be signed by the QMS Grievance Representative and mailed via Delivery Confirmation to the beneficiary/client and designated parties, including any provider identified by the beneficiary/client in the grievance, by the designated QMS Grievance Representative. The format of the resolution letter will be in the format and language that meets the beneficiary/client language preference and the applicable notification standards. If there is no address for the beneficiary/client, the e-filed letter will be stored in the designated grievance folder under the beneficiary's name. The beneficiary will also receive the NAR Your Rights, Language Assistance Taglines and Beneficiary Non-discrimination Notice with the Resolution Letter.

IX. Discrimination Grievance Information

A. The plan provides information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance 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. The beneficiary is not required to file a Discrimination Grievance with the health plan before filing the compliant directly with the Department of Health Care Services (DHCS) Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights. The beneficiary can file a discrimination grievance at any time with any of the entities below:

1. QMS Discrimination Grievance Coordinator

2. QMS Grievance Representative

3. HCA County Civil Rights Coordinator, Office of Compliance

4. Department of Health Care Services, Office of Civil Rights

5. U.S. Department of Health and Human Services, Office of Civil Rights

X. Discrimination Grievance Process

A. QMS has a designated Discrimination Grievance Coordinator (QMS MCST Manager/Service Chief) who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances or any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

B. The Discrimination Grievance Coordinator shall assign the grievance to an QMS Grievance Representative to initiate the investigation process and ensure the prompt and equitable resolution of discrimination-related complaints for beneficiaries/clients.

C. The QMS Grievance Representative shall follow the above protocol outlined in V-VIII and will notify the Office of Compliance immediately and the investigation shall be completed in partnership. The discrimination resolution letter will be developed in partnership with the Office of Compliance Civil Rights Coordinator prior to submitting the resolution letter and relevant supporting evidence to DHCS.

D. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the QMS Grievance Representative shall submit the following information regarding the complaint to the DHCS Office of Civil Rights via e-mail at DHCS.DiscriminationGrievances@dhcs.ca.gov and the Office of Compliance Civil Rights Coordinator at officeofcompliance@ochca.com.

1. The original complaint.

2. The provider's or other accused party's response to the complaint.

3. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the plan.

4. Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.

5. 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.

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