SECTION 5, CHAPTER 9, POLICY 015

BENEFICIARY GRIEVANCES

POLICY NUMBER:	5-9-015
SYSTEM OF CARE:	BEHAVIORAL HEALTH
FINALIZED DATE:	02.07.2023
EFFECTIVE:	07.01.2020
SUPERSEDES # :	Supersedes Policy #'s: 6-9-001 Beneficiary Grievances and Appeals 6-9-002 Beneficiary Grievance Procedure 6-9-005 Grievance and Appeal Recordkeeping 5-9-001 Beneficiary Grievances and Appeals 5-9-002 Beneficiary Grievance Procedure 5-9-005 Grievance and Appeal Recordkeeping PP 1100 Beneficiary Protection Problem Resolution Process

A. PURPOSE: To establish a uniform policy to ensure that Yolo County Health and Human Services (HHSA) Behavioral Health (BH) Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) Service providers are in compliance with State and Federal regulatory requirements regarding beneficiary grievances.

B. RELATED DOCUMENTS:

1. Grievance Form
2. Beneficiary Non-Discrimination Notice
3. Language Assistance Taglines
4. Notice of Grievance Resolution (NGR)

C. DEFINITIONS:

1. **Administrator**: Yolo County HHSA BH is the administrator of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan, hereby referred to as the "Administrator."

2. **Authorized Representative:** An individual or provider, with written consent by the beneficiary, representing them throughout the grievance process. At any time during the grievance process, the beneficiary may authorize a person to take action or use the process on their behalf, or to assist the beneficiary with the process.

3. **Grievance:** An expression of dissatisfaction about any matter other than an "adverse benefit determination." There is no distinction between an informal and formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination." Grievance topics may include, but are not limited to:
    a. **Access to Care:** One or more covered services, including the access line and linguistic services, are not available and/or not accessible.
        i. Services not available/accessible
        ii. Timeliness of Services

    b. **Quality of care:** The degree to which services for participants increase the likelihood of desired health outcomes and are consistent with current professional knowledge. This includes whether services are consistent with efficient and equitable outcomes in a safe, effective, and patient centered process.

    c. **Program requirements:** Any grievance where a beneficiary report's that the rules or requirements set by the program were not met.

    d. **Failure to respect Enrollee's/Patient's rights:** Beneficiaries are entitled to certain rights. Any violation of their rights would be included in this category.

    e. **Change of Provider:** Any grievance due to an unexpected change of provider. It may include the right to use a culture-specific provider or disagreeing with a transfer of care. This type of grievance may be part of a SMHS change of provider request.

    f. **Confidentiality:** Any grievance where a peer or staff member has shared personal information without the beneficiary's consent.

    g. **Discrimination Grievance**: a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including 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.

    h. **Other Category. Examples include, but are not limited to:**
        i. Financial

ii. Lost Property
iii. Operational
iv. Peer Behaviors
v. Physical Environment

4. **Network Providers:** Any provider, group of providers, or entity that has a network provider agreement with the Administrator and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2)

5. **Resolved:** A decision has been reached with respect to the beneficiary's grievance and the beneficiary has been notified of its disposition.

D. POLICY: The Administrator and its Network Providers shall ensure eligible beneficiaries have adequate information about the grievance system process, including information on procedures for filing and resolving grievances, a toll-free telephone number or a local telephone number, and the address for mailing grievances. The Administrator and Network Providers shall take, at minimum, the following actions:

a. Include information describing the grievance processes in Yolo County HHSA's beneficiary handbook, which shall meet state, federal regulations, and Yolo County HHSA guidelines and policies.

b. Post notices explaining the grievance process in locations at all offices or facilities owned or operated by the Administrator or Network Provider at which beneficiaries may obtain SMHS or SUD services. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff.
    i. This shall include additional, specific instructions on how to file a discrimination grievance with Yolo County, DHCS, and the United States Department of Health and Human Services Office of Civil Rights as applicable and information stating that the Contractor complies with all State and Federal civil rights laws.

c. Make available forms that may be used to file grievances and self-addressed envelopes that beneficiaries can access at all Administrator and Network Provider site locations without having to make a verbal or written request to anyone.

d. Give beneficiaries reasonable assistance in completing the grievance form and in taking any procedural steps towards filing the grievance, including but not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. The Administrator and its network providers shall allow a provider, or authorized representative, acting on behalf of the beneficiary and with the beneficiary's written consent to file a grievance.

Additionally, for SMHS providers, at the request of the beneficiary, the Administrator and its network providers shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance.

e. Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance.

f. Make written materials that are critical to obtaining services, including grievance notices, available in the prevalent non-English languages in the county.

g. SMHS providers shall identify the roles and responsibilities of the Administrator, the provider, and the beneficiary in the grievance documentation.

1. **Discrimination Grievances:**
   a. The Administrator and its Network Providers 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.

   b. The Administrator and its Network Providers shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints.
      i. The Administrator and its Network Providers shall not require a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

2. **Prohibition:** The Administrator and network providers shall never discourage the filing of grievances, shall allow beneficiaries to file grievances, and shall not subject a beneficiary to discrimination or any other penalty for filing a grievance.

3. **Linguistic and Cultural Needs:** The Administrator and network providers shall address the linguistic and cultural needs of its beneficiary population, as well as the needs of beneficiaries with disabilities and ensure that all beneficiaries have access to and can fully participate in the grievance system by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and responses to grievances, as well as access to interpreters, telephone relay systems

and other devices that aid individuals with disability to communication. Written materials that are critical to obtaining services, including grievance notices and/or resolutions, shall be made available in a format and language that meets applicable notification standards (42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10).

4. **Confidentiality:** The Administrator and network providers shall maintain confidentiality of each beneficiary's information.

5. **Grievance Process Exemptions:**
    a. Grievances received over the telephone or in-person by the Administrator or network providers, 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 acknowledgment and disposition letter. However, exempt grievances shall be logged and reported to the Administrator for state reporting and quality improvement purposes.

    b. Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If the Administrator or network provider receives a complaint pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

    c. Complaints reported to the Administrator by someone other than the beneficiary or an authorized representative reporting on behalf of the beneficiary shall be tracked and investigated for quality improvement purposes but shall not be considered a grievance in accordance with state and federal regulations.

6. **Record Keeping:** A grievance log shall be maintained in accordance with federal regulations (Title 42, CFR, Section 438.416). The log shall be maintained in a way that allows identification of which system of care the grievance originated (i.e., SMHS or SUD services) and in accordance with state and federal privacy and security requirements. Network provider grievance logs and associated grievance records shall be made available to the Administrator and DHCS upon request. The log shall contain at a minimum:
    a. The date and time of receipt of the grievance;

    b. The name of the beneficiary filing the grievance;

    c. The name of the representative recording the grievance;

    d. A description of the complaint or problem (the nature of the grievance);

e. A description of the action taken by the Administrator or network provider to investigate and resolve the grievance;

f. The proposed resolution by the Administrator or network provider, including the date(s) for each level of review and related resolution information, if applicable;

g. The name of the Network Provider or staff responsible for resolving the grievance;

h. The final disposition of the grievance;

i. The date of notification to the beneficiary of the resolution;

j. If there has not been final disposition of the grievance, the reason(s) shall be included in the log.

7. **Quality Improvement:** Network providers shall be required to submit issues identified as a result of grievances in accordance with state, federal and Yolo County contractual requirements. These issues may be transmitted to the Administrator's BH Quality Improvement Committee (QIC), Provider Meetings, administration, or other appropriate body for systematic aggregation and analysis for the purpose of quality improvement and performance monitoring activities. A written record of grievances must be available to the Department of Health Care Services (DHCS) and the Administrator upon request or in accordance with Yolo County contractual requirements. Grievances reviewed at the forums identified above, shall include, but not be limited to, issues related to access and quality of care. Appropriate action shall be taken to remedy any problems identified.

E. PROCEDURE:

1. **Filing a Grievance**:
   a. A beneficiary or authorized representative may file a grievance at any time either orally or in writing.

   b. A beneficiary does not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievances will be analyzed to monitor trends.

   c. Network Providers shall adhere to any additional requirements outlined within Yolo County HHSA BH contracts.

2. **Grievance Receipt:** The grievance shall be recorded in a grievance log within one (1) working day of the date of receipt, in accordance with state and feral guidelines, or as specified in the Yolo County HHSA BH contract. The log shall be updated throughout the grievance process to capture all the required information as outlined under record keeping requirements.

3. **Grievance Acknowledgement:** The beneficiary shall be provided a written acknowledgement of receipt of the grievance unless an exemption applies. The written acknowledgement to the beneficiary shall be postmarked within five (5) calendar days of receipt of the grievance and shall include:
    a. The date of receipt as well as the name, telephone number, and address of the representative who the beneficiary may contact about the grievance.

    b. The following attachments:
        i. Beneficiary Non-Discrimination Notice
        ii. Language Assistance Taglines

4. **Grievance Investigation:** Grievances shall be investigated in accordance with the following requirements at a minimum:
    a. The Program Manager, Supervisor, or designee determines the appropriate investigating staff for the grievance;

    b. Each issue identified is addressed with a final disposition reached; and

    c. The Administrator and network providers shall ensure that individuals making decisions on grievances:
        i. Are not involved in any previous level of review or decision-making and were not subordinates of any individual who was involved in a previous level of review or decision-making regarding the grievance.
        ii. Have the appropriate clinical expertise, as determined by DHCS, in treating the beneficiary's condition or disease, if the grievance involves the denial of a request for an expedited appeal, or if the grievance involves clinical issues.
        iii. Take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's authorized representative.

5. **Standard Grievance Resolution**: Grievances shall be resolved as expeditiously as the beneficiary's health condition requires and no later than 90 calendar days from the date of receipt of the grievance.
    a. The resolution shall be provided in writing to the beneficiary, or the appropriate representative, using the Notice of Grievance Resolution (NGR) or other approved DHCS template, and shall contain a clear and concise explanation of the final decision in a format and language that meets

applicable notification standards (42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10). The notification shall also include the two required attachments (i.e., Beneficiary Non-Discrimination Notice; Language Assistance Taglines)

b. If the beneficiary could not be contacted (e.g., unable to hand-deliver the NGR with attachments and there is no current address on file), there shall be documentation of the notification efforts in the grievance log.

c. When a grievance is investigated by Yolo County Behavioral Health Quality Management, providers identified by the beneficiary, or as requested by the beneficiary or their authorized representative, shall be notified of the grievance status and final disposition.

d. Network Providers shall adhere to any additional requirements outlined within Yolo County HHSA BH contracts and/or state and federal guidelines.

6. **Grievance Resolution Extension**: Federal regulations allow an extension of an additional 14 calendar days if the beneficiary requests the extension or it is demonstrated (to the satisfaction of the Administrator and DHCS, upon request) that there is a need for additional information and how the delay is in the beneficiary's interest. In these instances, the following shall be completed:
    a. If a resolution of a grievance is not reached within the standard 90 calendar days as required, the beneficiary shall be provided the applicable Notice of Adverse Benefit Determination (NOABD) and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.

    b. If the standard resolution timeframe is extended, not at the request of the beneficiary, the following shall be completed:
        i. Provide the beneficiary prompt oral notice of the delay;
        ii. Within two calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if the beneficiary disagrees with that decision; and
        iii. Resolve the grievance expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

7. **Substance Use Disorder Programs: Additional Requirements**
    a. The administrator and its network providers shall report complaints to DHCS via secure, encrypted email within two business days of completion
        i. Network providers shall copy Yolo County Quality Management (HHSAQualityManagement@yolocounty.org) on these communications for tracking purposes.

b. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using the Complaint Form which is available and may be submitted online through DHCS' Licensing and Certification- Complaints page.
    i. Network providers are responsible for monitoring this page for updates.
    ii. Network providers shall notify Yolo County Quality Management (HHSAQualityManagement@yolocounty.org) of any complaints they submitted online.

8. Discrimination Grievance Resolution: Additional Requirements

a. Network providers shall submit the following detailed information to DHCS Office of Civil Rights' designated Discrimination Grievance email box via secure, encrypted email within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary:
    i. The original complaint.
    ii. The provider's or other accused party's response to the grievance.
    iii. Contact information for the provider's personnel responsible for the provider's investigation and response to the grievance.
    iv. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance.
    v. All correspondence with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary.
    vi. The results of the provider's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

b. Providers shall copy Yolo County Quality Management (HHSAQualityManagement@yolocounty.org) on the above communications for tracking purposes.

F. REFERENCES:

1. DHCS MHSUDS INFORMATION NOTICE 18-010E
2. DMC-ODS INTERGOVERNMENTAL AGREEMENT
3. DHCS YOLO COUNTY MENTAL HEALTH PLAN CONTRACT
4. 42 CFR § 438.402
5. 42 CFR § 438.408
6. 9 CCR § 438.10
7. 9 CCR § 1850.205

Approved by:

Karleen Jakowski _____ **02/09/2023**

Karleen Jakowski, LMFT, Mental Health Director **Date**
Yolo County Health and Human Services Agency