POLICY/PROTOCOL and PROCEDURE	Policy Number-A-023
Beneficiary Problem Resolution (Grievance and Appeals)	Date: January 24, 2020 Revised: July 1, 2022
	Supersedes: A-023 Grievance Policy – Oct 2016

I. PURPOSE

To implement the Federal Medicaid Managed Care Regulations pertaining to the Medi-Cal Beneficiary Problem Resolution Process.

II. SCOPE

All Kings County Mental Health Plan (MHP) Providers, County and Contracted.

III. DEFINITIONS

Action: See "Adverse Benefit Determination"

Adverse Benefit Determination (ABD): One or more of the following:

- Denial or limitation of authorization of a requested service, including the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as determined by the department
- Failure to act within the resolution time frames for Grievances, Standard Appeals, or Expedited Appeals
- For a resident of a rural area with only one (1) Managed Care Plan (MCP), the denial of the beneficiary's request to obtain services outside the network
- Denial of a beneficiary's request to dispute financial liability

Aid Paid Pending: The right of a beneficiary to request current aid or services continue until the resolution of an Appeal or State Fair Hearing.

Appeal: A request for a review of an ABD.

Authorized Representative: A person designated by the beneficiary to represent him or her in the Grievance, Appeal, or State Fair Hearing process.

Expedited Appeal: An Appeal is to be "expedited" if the 30-day timeline for resolution of a Standard Appeal could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning.

Exempt Grievance: Grievances received over the telephone or in person by the Plan, or a network provider of the Plan, that are resolved to the patient's satisfaction by the close of business day following receipt are exempt from the requirement to send a written acknowledgement and/or notice of grievance resolution letter.

Grievance: For the purpose of this policy, Grievance refers an expression of dissatisfaction about any matter other than adverse benefits determinations.

Health Insurance Portability and Accountability Act (HIPAA): Legislation that provides data privacy and security provisions for safeguarding medical information.

Notice of Adverse Benefit Determination (NOABD): A formal letter informing a beneficiary of an ABD.

Notice of Appeal Resolution (NAR): A formal letter informing the beneficiary and/or representative of the final disposition of an Appeal. Contents shall include:

- Results of the resolution and the date it was completed.
- The reasons for the determination and any criteria, clinical guidelines or medical policies used in reaching the determination.
- If MHP determination specifies the requested service is not a covered benefit, the MHP shall include in its written response the provision in the DHCS Contract, Evidence of Coverage or Member Handbook that excludes the service. This response shall also identify the document and page where the provision is found and/or provide a copy.
- The beneficiary's right to request a State Fair Hearing no later than 120 days from the date of the written NAR and instructions on how to request a State Fair Hearing.
- The beneficiary's right to request and receive continuation of benefits while the State Fair Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

Patients' Rights Advocate (PRA): Individual responsible for ensuring the administration of public assistance mental health programs comply with the laws and regulations governing the rights of all mental health consumers within the MHP.

Quality Assurance Clinician (QAC): A licensed clinician, or designee, who tracks and investigates Grievances and Appeals. The QAC is also tasked to act as the primary representative for State Fair Hearings.

IV. POLICY

A. Upon admission to the MHP all beneficiaries will be notified of the Problem Resolution Process. The notification includes:

1) A description of the Problem Resolution Process, the Grievance and Appeal Procedure and the State Fair and Aid Paid Pending Hearing Process and information on how to initiate these processes

2) A designated person to contact for assistance, including the address and phone number

B. The MHP will provide access to the appeal and grievance process for enrollees. This process has only one (1) level of appeal. The MHP will document consumer's concerns and facilitate resolution of these concerns in a timely manner. All beneficiaries shall be protected equally by the Beneficiary Problem Resolution process.

C. Beneficiaries will not be subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

D. Beneficiaries will not be held financially liable for appeals involving a second opinion.

E. No punitive action will be taken against a provider who supports a beneficiary in exercising the problem resolution process or requests an appeal or expedited resolution on behalf of the beneficiary.

F. The decision makers involved with the disposition/resolution of an Appeal or Grievance will not have been involved in, or under the supervision of staff involved in, previous levels of review or decision-making resulting in the ABD.

G. The MHP will ensure the participation of individuals with authority to require corrective action.

H. The MHP ensures that all individuals making decisions on clinical Appeals take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's designated representative, regardless of whether such information was submitted or considered in the initial ABD.

I. The MHP ensures that the QAC has clinical expertise in treating the beneficiary's condition and can make determinations for the following situations:

1) Appeals based on lack of medical necessity

2) Grievances regarding denials or expedited resolution of an appeal

3) Grievances and Appeals that involve clinical issues

J. The Quality Assurance Clinician, or designee, will inform all involved parties that the beneficiary is to be free of discrimination or penalty for initiating a Grievance, Appeal, or State Fair Hearing. The beneficiary is encouraged to report any experience or perception of discrimination or penalty to the PRC, or designee.

K. Maintenance of Beneficiary Confidentiality

1) The confidentiality of the beneficiary and/or authorized representative will be maintained throughout the problem resolution process.

2) Appeal forms, Grievance forms, and self-addressed envelopes are available in the waiting areas of all providers and/or upon request.

3) All rules and regulations concerning confidential treatment of patient information (HIPPA compliance) are followed in the problem resolution process.

4) All forms and documents related to the problem resolution process will be kept in secure files by the PRC/QAC. These files are kept separate from the beneficiary's medical record.

L. Beneficiary has the right to:

1) File a Grievance, Appeal or Expedited Appeal verbally or in writing to establish the earliest possible filing date. Any standard appeal, however, must be followed up with a written appeal request.

2) File a Grievance verbally or in writing at any time.

3) File an Appeal verbally or in writing within 60 calendar days of physically receiving or date of mailing an NOABD. Standard verbal appeals must be followed up in writing.

4) Request an Expedited Appeal within 60 calendar days of physically receiving or date of mailing an NOABD. If request is granted, a verbal request does not have to be followed up in writing.

5) Be free of discrimination or penalties for filing a Grievance or Appeal.

6) Authorize another person to act on their behalf during the grievance and appeal process. The authorized person may potentially have access to protected health information. Beneficiary can select a provider as his/her representative.

7) Request the QAC or the PRA assist them through the grievance and appeal process.

8) Request and receive information regarding basis for an ABD, including applicable regulations, policies and procedures, and clinical documentation used to support an action. This could also be a review of the case file materials pertaining to the Appeal. All materials will be provided at no cost. This could occur before or during the appeal/expedited appeal process.

9) A reasonable opportunity to present evidence, and allegations of fact or law, in person, over the phone, or in writing. The PRC, or designee, will inform the beneficiary of the time limitations on providing this opportunity.

10) Request a State Fair Hearing related to the denial, termination, or reduction in services after the problem resolution process has been exhausted at the county level.

a. A hearing must be requested by the beneficiary within 120 calendar days of physically receiving or date of mailing of the Notice of Appeal Resolution (NAR).

b. A minor can file for a Fair Hearing as long as they are competent to do so or as long as their guardian is in agreement.

c. Conservators may request a Fair Hearing on behalf of a conservatee. A conservatee may not initiate the request.

d. A hearing can be requested if the MHP fails to send a resolution notice in response to the Appeal within the required timeframe.

M. Reporting And Accountability

1) The Quality Assurance Clinician will report on the Beneficiary Problem Resolution status:

a. To the Quality Improvement Committee (QIC) quarterly, and

b. To the California Department of Health Care Services annually using the state ABGAR document.

2) The Quality Assurance Clinician or designee will maintain a log documenting all valid Grievances, Appeals and Expedited Appeals. The log shall contain, at minimum:

a. The date and time of receipt of the Grievance or Appeal

b. The name of the beneficiary

c. The name of the beneficiary's representative, if applicable

d. A description of the complaint or problem

e. A description of the action taken by the MHP to investigate and resolve the Grievance or Appeal

f. The proposed resolution

g. The name of the MHP provider or staff responsible for resolving the Grievance or Appeal

h. The date of notification to the beneficiary of resolution

V. PROCEDURE

A. Grievances

1) If the beneficiary presents a complaint to an MHP provider that cannot be initially resolved, the MHP provider informs the beneficiary that they may submit a written Grievance, or phone the Patients' Rights Advocate at 1(866)701-5464. If written Grievances are submitted to any MHP provider, they must be sent expediently to the PRA.

2) The PRA, or designee, logs the Grievance. The Grievance Log will be updated as appropriate throughout the Grievance process.

3) The PRA, or designee, acknowledges all Grievances in writing, within five (5) calendar days of receipt. This acknowledgement shall note that the Grievance has been received, the date received and the name and contact for the PRA. Exempt Grievances: Grievances received over the telephone or in-person by the Plan, or a network provider of the Plan, that are resolved to the patient's satisfaction by the close of the next business day following receipt are EXEMPT from the requirement to send a written acknowledgement and/or notice of grievance resolution letter.

4) The PRA, or designee, has 90 days from the receipt of a Grievance to determine a resolution.

5) The PRA, or designee, must include the following in the written resolution:

a. The results/disposition of the Grievance

b. The date the resolution/disposition was reached

6) The PRA must also inform the provider involved, preferably in writing or via email, of the outcome of the grievance and this should be documented in the log.

B. Standard Appeals

1) A beneficiary or authorized representative, if applicable, presents a verbal or written request to review an ABD to the Quality Assurance Clinician, or designee.

a. Verbal Appeals must be followed up with a written Appeal signed and dated by the beneficiary or authorized representative. The date of the oral appeal establishes the filing date for the appeal.

2) The beneficiary must file an Appeal within 60 days of physically receiving or date of mailing the NOABD.

a. If a beneficiary is currently receiving services, an Appeal must be filed within ten (10) days of physically receiving or date of mailing the NOABD if the beneficiary requests that mental health services continue while waiting for an Appeal decision. An authorized representative can not request continuation of benefits.

i. The beneficiary's benefits are continued through the outcome of the appeal when all of the following are met:

a. The beneficiary files the request of an appeal within 60 days.

b. The appeal involves the termination, suspension, or reduction of previously authorized services.

c. The services were ordered by an authorized provider

d. The period covered by the original authorization has not expired. And,

e. The beneficiary files for continuation of benefits within 10 days.

ii. In some circumstances, the beneficiary may need to pay for the services.

3) The Quality Assurance Clinician, or designee, logs the Appeal within one (1) working day of the receipt of the Appeal. The Appeal Log will be updated as appropriate throughout the Appeal process.

4) The Quality Assurance Clinician, or designee, acknowledges all Standard Appeals in writing, within five (5) calendar days of receipt. This acknowledgement shall note that the Appeal has been received, the date received and the name and contact for the Quality Assurance Clinician.

5) The Quality Assurance Clinician, or designee, has 30 calendar days from the date of receiving the Appeal to make a final decision. This timeframe may be extended by up to 14 days in certain circumstances if requested by the beneficiary or the Plan determines that additional information is needed and it is in the best interest of the beneficiary. If the timeframe is extended:

a. The Quality Assurance Clinician, or designee, shall send written notification of the extension within two (2) calendar days to the beneficiary on the date the decision to extend is made.

i. The notification of the extension shall advise the beneficiary of the reason for the extension and the beneficiary's right to file a Grievance if the beneficiary disagrees with the extension.

b. The Quality Assurance Clinician, or designee, will make reasonable efforts to provide the beneficiary with prompt oral notice of the extension.

6) The Quality Assurance Clinician will arrange for a time for the beneficiary to present new information and will have the prior ABD reviewed. This may also be done in person or over the phone, if appropriate.

7) After the resolution is determined, the Quality Assurance Clinician, or designee, must provide a NAR to the beneficiary or authorized representative.

a. The QAC must also inform the provider involved, preferably in writing or via email, of the outcome of the appeal and this should be documented in the log.

C. Expedited Appeals

1) An Appeal can be "expedited" if the 30-day timeline for resolution of a Standard Appeal could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning.

a. The beneficiary or authorized representative must specifically request an Expedited Appeal.

b. The beneficiary must request an Expedited Appeal within 60 days of physically receiving or date of mailing the NOABD.

2) A beneficiary or authorized representative, if applicable, presents a verbal or written request to review an ABD to the Quality assurance Clinician, or designee.

a. An Expedited Appeal submitted verbally does not have to be followed up with a written Appeal.

b. The nature of the problem must be a request to review an ABD.

3) The Quality Assurance Clinician logs the Expedited Appeal within one (1) working day of the receipt of the Expedited Appeal.

4) The Quality Assurance Clinician, or designee, has 72 hours after receipt of an Expedited Appeal in which to reach a decision. This timeframe maybe extended by up to 14 days in certain circumstances if requested by the beneficiary or the Plan determines that additional information is needed and it is in the best interest of the beneficiary. If the timeframe is extended:

   a. The Quality Assurance Clinician, or designee, shall send written notification of the extension to the beneficiary within two (2) calendar days of the date the decision to extend is made.

      i. The notification of the extension shall advise the beneficiary of the reason for the extension and the beneficiary's right to file a Grievance if the beneficiary disagrees with the extension.

   b. The Quality Assurance Clinician, or designee, will make reasonable efforts to provide the beneficiary with prompt oral notice of the extension.

5) If a request for an expedited appeal is denied, the QAC will make reasonable efforts to provide the beneficiary with prompt oral notice of the decision.

   a. The Quality Assurance Clinician then follows the timeline and procedure for resolving a standard Appeal. (See "Standard Appeal")

6) The Quality Assurance Clinician will arrange for a time for the beneficiary to present new information and will have the prior ABD reviewed. This may also be done in person or over the phone, if appropriate

7) The Quality Assurance Clinician, or designee, must provide a NAR and applicable "Your Rights" attachment to the beneficiary or authorized representative.

   a. The Quality Assurance Clinician must also inform the provider involved, preferably in writing or via email, of the outcome of the appeal and this should be documented in the log.

8) In addition to the NAR, the QAC, or designee, must make reasonable efforts to provide the beneficiary with a verbal notice.

9) If services are deemed necessary, they must be authorized within 72 hours of the date the determination to resume services is made.

D. State Fair Hearing

1) Upon receipt of the NAR resulting in an Appeal denial, the beneficiary can file for a Fair Hearing within 120 calendar days or as or as soon as the Plan fails to adhere to the notice and timing requirements above.

a. Beneficiaries may request the hearing by:

i. Calling the toll-free number included on the NAR form

ii. Completing the appropriate section on the NAR and sending it to State Department of Social Services

b. Non Medi-Cal beneficiaries may not request a State Fair Hearing.

2) Upon being notified of a pending State Fair Hearing by the Department of Health Care Services, the QAC, or designee, shall review the request for validity and contact the beneficiary regarding the dispute.

a. If the QAC, or designee, believes that the beneficiary request is invalid, a formal request can be made in writing to the State Fair Hearing office noting:

i. The Request for Dismissal

ii. The regulations, laws or rules supporting a Request for Dismissal

b. If the beneficiary request appears valid or the Request for Dismissal is denied, the QAC, or designee, can attempt to resolve the dispute prior to the hearing; if this resolution does not satisfy the beneficiary then the efforts to resolve the matter should be logged and later documented in the Statement of Position.

i. The beneficiary or the beneficiary's representative can withdraw the request for a State Fair Hearing at any time; however, this must be completed with the State Fair Hearing office.

c. If requested, the Quality Assurance Clinician, or designee, shall provide the documents supporting the disputed action to the beneficiary or the beneficiary's representative. The beneficiary or beneficiary's representative can also view clinical documentation used to support the action.

d. If the request for a State Fair Hearing is not withdrawn, the Quality Assurance Clinician, or designee, must submit a Statement of Position to the

State Fair Hearings office no later than three (3) business days prior to the hearing date. The Statement of Position, at minimum, includes:

i. The reason for the hearing

ii. The facts regarding the action

iii. The laws, regulations, policies and/or rules supporting the action

iv. The official position and request of the County

v. Any supporting documentation labeled as “exhibits”, if necessary

e. If the determination of the Administrative Law Judge overseeing the hearing is in favor of the beneficiary, the QAC, or designee, will review the determination. A Request for a Rehearing may be submitted in writing to the State Hearing office within 30 days of receiving the hearing decision. If the Quality Assurance Clinician, or designee, does not file a Request for a Rehearing the authorized services must be initiated within 72 hours of the notification of reversal of the ABD.

f. If the action is sustained by the hearing decision, Kings County Behavioral Health may institute recovery procedures against the beneficiary to recoup the cost of any services furnished to the beneficiary, to the extent they were furnished solely by reason of Section 42 CFR 431.230(b) of the Code of Federal Regulations.

3) Reporting

a. The Quality Assurance Clinician will keep a separate file for any State Fair Hearing proceeding.

b. This file shall contain:

i. The beneficiary request for a State Fair Hearing

ii. Notes and documentation of efforts to resolve the matter outside of the hearing, including any documented efforts to resolve the matter prior to the hearing and/or after the ruling

iii. The Statement of Position

iv. The State determination

v. State Fair Hearings are not reported to the Department of Health Care Services and are not tracked in the ABGAR document that is submitted to the Department of Health Care Services annually.

Reference:

A. Code of Federal Regulations (CFR) Title 42, part 438, subpart F

B. CFR Title 42 Section 438.404 (c)(2)

C. California Code of Regulations (CCR):

1. Title 9, Section 1810.405, 1810.223, 1830.210, 1830.215, 1830.220, 1850.205, 1850.206, 1850.207, 1850.208 and 1850.210

2. Title 22, Section 51014.1

D. Welfare and Institutions Code (W&I), Section 10950 – 10967

E. California Department of Mental Health (DMH) Information Notice:

1. 05-03: Medi-Cal Requirements for Aid Paid Pending

2. 03-13: Implementation of Federal Medicaid Managed Care Regulations.

F. California Department of Health Care Services (DHCS) All Plan Letter 17-006

G. Kings County Mental Health Plan (MHP) Contract

Approved by:

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