El Dorado County Health and Human Services Agency Behavioral Health Division Policy and Procedure			
SUBSTANCE USE DISORDER SERVICES PROGRAM – DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM GRIEVANCES, APPEALS & FAIR HEARING		Policy Number	**N-SUDS-003**
		Date Adopted	3-14-19
		Date Revised	
Approved By	Donald Semon, Director	Page Number	1 of 26

PURPOSE

The El Dorado County Health and Human Services Agency, Behavioral Health Division-Substance Use Disorder Services (BHD-SUDS) must establish internal grievance procedures under which Medi-Cal beneficiaries, or providers on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

POLICY

The County's grievance system must include a grievance process, appeal process, and access to the State's Fair Hearing process. The Grievance and Appeal System shall operate in accordance with all applicable federal regulations and DMC-ODS contract requirements. El Dorado County DMC-ODS must ensure minimum standards are met at all times.

PROCEDURE

EDC DMC-ODS shall implement the following procedures for processing an applicant's or beneficiary's grievances, appeals and fair hearings within the EDC DMC-ODS Plan.

Grievances

A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may be filed at any time, orally or in writing. Possible subjects for grievances include, but are not limited to:

- The quality of care of services provided.

- Interpersonal relationships (such as rudeness of a provider or employee).
- Failure to respect the enrollee's rights.

NOTE: There is no distinction between an informal and formal grievance. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination" (see below). Even if a complainant expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance.

Written and oral information explaining the informal complaint process, formal grievance procedures, and fair hearings shall be provided to members. Written information must be provided members periodically stating that the formal grievance process may be started without first going through the informal process.

Applicants and plan members may submit a grievance in either written or verbal format. Applicants and members may report a verbal grievance to the 24/7 access line, Patient's Rights Advocate, any County SUD staff, or direct service provider.

Grievances can be filed by phone, in writing, in person, or electronically:

- By phone:

1-530-621-6290 or 1-800-929-1955 Monday through Friday, 8:00 a.m. through 5:00 p.m. or 711 for the California Relay Service.

- In writing, using a grievance form letter mailed to:

El Dorado County Health and Human Services Agency
Behavioral Health Division
ATTN: Problem Resolution Coordinator
768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619

- In person at network provider.

Notice to plan applicants and members

Plan applicants and members shall be informed of the process for reporting and resolution of grievances that includes:

- The provision of written procedures for reporting and resolving grievances to each member during the initial assessment for services.
- The receipt of grievance and appeal procedure information through written or verbal means during the provision of DMC-ODS services.
- Posted notices at every direct service provider facility including contracted, individual, and group providers.
- Twenty-four (24) hour a day access to the grievance information and assistance by calling the access line.

NOTE: All written communications with plan applicants and members shall include the mandated DHCS **Language Assistance Notice** including the current EDC DMC ODS

telephone and TTY numbers for language assistance services.

Assistance to plan applicants and enrollees

EDC DMC ODS Problem Resolution Coordinator shall provide applicants and plan members with reasonable assistance in completing forms and taking other procedural steps related to a Grievance and/or Appeal (Standard and Expedited). This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

The Problem Resolution Coordinator is responsible for:

- Logging and maintaining files related to Grievances, Appeals and State Fair Hearings.
- Maintaining communication with the Enrollee or Applicant or plan member, which will include status updates and issuing the Notice of Resolution for Grievances and Appeals.
- Assuring that Grievance and Appeal investigations are conducted in compliance with regulations and in compliance with the required timeframes.
- Prepare requiring reporting to DHCS and the Quality Improvement program related to Grievances, Appeals and State Fair Hearings.

EDC DMC ODS shall ensure that punitive action is not taken against an applicant or plan member who submits a Grievance, Appeal or State Fair Hearing, or against a

provider who supports an applicant or plan member Grievance, Appeal or State Fair Hearing.

EDC DMC ODS shall ensure that:

- Staff who rule on Grievances and Appeals were not involved in any previous level of review or decision-making regarding the Notice of Adverse Benefit Determination or previous level of review, nor a subordinate of any such staff. In such a circumstance, the ineligible EDC DMC ODS staff member shall immediately refer the applicant or plan member to another EDC DMC ODS staff member for prompt assistance.
- In deciding any of the following matters, staff possesses appropriate clinical expertise in treating the enrollee's condition or disease.
  - An Appeal of a denial that is based on lack of medical necessity.
  - A Grievance regarding denial of Expedited Resolution of an Appeal.
  - A Grievance or Appeal that involves clinical issues.

Staff must consider all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

EDC DMC ODS shall:

- Treat that oral inquiries seeking to Appeal an Adverse Benefit Determination as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing, unless the Applicant or plan member or the provider

requests an Expedited Resolution of the Appeal.

- Afford the applicant or plan member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. In the case of an Appeal, EDC DMC ODS must inform the applicant or plan member of the limited time available for this sufficiently in advance of the resolution timeframe for an Appeal.
- Provide the applicant or plan member and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by EDC DMC ODS (or at the direction of EDC DMC ODS) in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for an Appeal.

An informational document explaining the Grievance and Appeal processes, as well as Grievance and Appeal forms and self-addressed envelopes for submitting such forms shall be available at each of EDC DMC ODS's service sites and each contracted provider service sites. These items must be available in English and Spanish and be easily accessible. Clients should not have to ask anyone to obtain these documents. The format of these documents shall be in compliance with federal and State regulations.

Individuals filing Grievance or Appeal may also authorize another person to act on their behalf. This authorization may be made on the Grievance and Appeal forms. EDC DMC ODS shall include the Enrollee or Applicant or plan member and his or her

representative, or the legal representative of a deceased Enrollee or Applicant or plan member's estate, as parties to the Grievance or Appeal.

Acknowledgement of grievances

Send complainants a written acknowledgement of receipt of the grievance. The acknowledgment letter shall be on **El Dorado County Behavioral Health letterhead** and include:

- Date of receipt
- Name, telephone number, and address of the EDC DMC ODS Plan
- Representative to contact about the complaint.

NOTE: The written acknowledgement must be postmarked within five (5) calendar days of receipt of the grievance.

Grievances received by telephone or in-person or by a network provider that are resolved to the applicant or plan member'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.

"Resolved" means that the Plan has reached a decision with respect to the grievance and notified the complainant of the disposition.

Investigation of grievances

Grievances shall be investigated by the Problem Resolution Coordinator. In the absence of the Problem Resolution Coordinator or if the grievance relates to the Problem Resolution Coordinator, grievances may be investigated by the following staff:

(1) Supervisor or Manager of the program identified in the Grievance;

(2) SUDS QA/UR Supervisor

(4) Deputy Director with responsibility over Behavioral Health services;

(5) Assistant Director with responsibility over Behavioral Health services;

(6) Medical Director;

(7) Mental Health Director or his/her designee.

Time frames for grievance resolution

Grievances must be resolved no later than 90 calendar days from receipt. The timeframe for resolving grievances related to disputes of a decision to extend the timeframe for making an authorization decision shall no exceed 30 calendar days.

NOTE: This timeline can be extended for an additional 14 calendar days if the complainant requests the extension or the EDC DMC ODS shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the complainant's interest.

Use the DHCS **Notice of Grievance Resolution** template to notify complainants of the results of the grievance resolution. The notice shall be printed on El Dorado County Behavioral Health letterhead and contain a clear and concise explanation of the decision.

If resolution of the complaint is not reached within 90 calendar days, complainants shall be provided notice using the DHCS template **Failure to timely resolve grievances and appeals** and the notice "**Your Rights under Medi-Cal**." This notice shall include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.

If this timeframe is extended and not at the request of the complainant, EDC DMC ODS shall:

- Provide the complainant oral notice of the delay within two calendar days of making the decision.
- Provide the complainant written notice of the reason for the decision to extend the timeframe and inform the complainant of their right to file a grievance if he/she disagrees with that decision.

Adverse Benefit Determinations

Adverse Benefit Determination means any of the following:

- 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.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure of EDC DMC ODS to act within the timeframes established by federal and State regulations regarding the resolution of Grievances and Appeals (both

Standard and Expedited Resolutions).

- The denial of an applicant or plan member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles and coinsurance.

Applicants and plan members shall receive Written Notice of Adverse Benefit Determinations (NOABD). Notices must explain all of the following:

1. The adverse benefit determination the Plan has made or intends to make;
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The Plan shall explicitly state why the applicant or plan member's condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
4. The 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 adverse benefit determination.

Notifying network providers of Adverse Benefit Determinations

Decisions shall be communicated to the network provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, include the name and direct telephone number or extension

of the decision-maker. Notices shall be made within two (2) business days of the decision of:

- Denial of payment.
- Action denying the provider's claim.
- Decisions resulting in denial, delay, or modification of all or part of the requested EDC DMC-ODS services.

Notifying Applicants and Plan Members of Adverse Benefit Determinations

Applicants and plan members shall be notified at least ten (10) days before the date of action for termination, suspension, or reduction of a previously authorized EDC DMC-ODS service Exceptions include:

- Confirmed death of an applicant or member;
- Clear written statement signed by applicant or plan member he or she no longer wishes services; or
- The applicant or plan member provides information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information
- The applicant or plan member has been admitted to an institution where he is ineligible under the plan for further services;
- The applicant or plan member's whereabouts are unknown and the post office returns agency mail indicating no forwarding address
- The applicant or plan member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
- A change in the level of medical care is prescribed by the applicant or plan

member's physician;

- The notice involves an adverse determination made with regard to the preadmission screening for mentally ill and mentally retarded individuals;
- The date of action will occur in less than 10 days.

NOTE: When EDC DMC ODS has facts indicating that action should be taken because of probable fraud by the applicant or plan member and the facts have been verified, if possible, through secondary sources the notice period may be shortened to five (5) days before the date of the action.

Written notices of Adverse Benefit Determinations for applicants and plan members

Decisions shall be communicated to the applicant or plan member in writing using the appropriate DHCS template below on **El Dorado County Behavioral Health letterhead** and include the DHCS notice **Your Rights under Medi-Cal.**

NOTE: All notices shall also include the DHCS **Language Assistance Notice** including the current EDC BH telephone and TTY numbers for language assistance services.

NOTE: This decision must be communicated to the affected plan provider within 24 hours.

Denial of authorization for requested services

Use this template when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Also use this template for denied residential service requests.

Denial of payment for a service rendered by provider

Use this template when the Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a plan member.

Delivery system

Use this template when the Plan has determined that the applicant or plan member does not meet eligibility criteria. The applicant or plan member will be referred to other appropriate system or services.

Modification of requested services

Use this template when the Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

Termination of a previously authorized service

Use this template when the Plan terminates, reduces, or suspends a previously authorized service.

Delay in processing authorization of services

Use this template when there is a delay in processing a provider's request for authorization of residential services. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the plan member or provider, and/or those granted when there is a need for additional information from the member or provider, when the extension is in the member's interest.

Failure to provide timely access to services

Use this template when there is a delay in providing the applicant or plan member timely services, as required by the timely access standards applicable to the delayed service.

Dispute of financial liability

Use this template when the Plan denies an applicant or plan member's request to dispute financial liability, including cost-sharing and other financial liabilities.

Appeals of Adverse Benefit Determinations

An Appeal is a review by EDC DMC ODS of an Adverse Benefit Determination. Plan applicants and members must appeal an adverse benefit determination within 60 calendar days from the date of the Notice of Adverse Benefit Decision (NOABD).

Methods of filing appeals:

- Plan applicants and members may file an appeal either orally or in writing.
- An oral appeal (excluding expedited appeals) must be followed by a signed written appeal. The date of the oral appeal establishes the filing date for the appeal.
- Appeals filed by a network provider on behalf of the plan applicant or member require written consent from the applicant or member.

NOTE: If the Plan does not receive a written, signed appeal from the applicant or plan member, the Plan shall neither dismiss nor delay resolution of the appeal.

Appeals shall be investigated by any of the following EDC DMC ODS staff:

- Supervisor or Manager of the program identified in the Appeal;
- SUDS QA/UR Supervisor
- Deputy Director with responsibility over Behavioral Health services;
- Assistance Director with responsibility over Behavioral Health services;
- Medical Director;
- DMC ODS director or his/her designee.

Acknowledgment of appeals

EDC DMC ODS shall provide to the applicant or plan member written acknowledgement of receipt of the appeal. The acknowledgment letter shall include:

- Date of receipt
- Name, telephone number, and address of EDC DMC ODS representative who the applicant or plan member may contact about the appeal.

NOTE: The written acknowledgement to the applicant or plan member must be postmarked within five (5) calendar days of receipt of the appeal.

Appeals of Adverse Benefit Determinations shall be resolved within 30 calendar days of receipt.

EDC DMC ODS may extend the resolution timeframe for appeals by up to 14 calendar days if either of the following two conditions apply:

- The applicant or plan member requests the extension;
- EDC DMC ODS demonstrates, to the satisfaction of DHCS upon request, that

there is a need for additional information and how the delay is in the applicant or plan member's best interest.

Steps for investigation of grievances and appeals

1. Staff shall conduct a fact-finding investigation to identify information relevant to the Grievance or Appeal, and options related to the client's expressed outcome and/or resolution of the issue. The investigator will review relevant documents, research any pertinent data, and conduct interviews, as appropriate.
2. In the event the investigator is in need of an extension of the timeframe for completion of the investigation, the investigator will consult with the Problem Resolution Coordinator for approval for the extension and if granted, the Problem Resolution Coordinator will notify the Enrollee or Applicant.
3. The investigator will report the outcome of the investigation back to the Problem Resolution Coordinator upon completion of the investigation.
4. For Appeals, the Problem Resolution Coordinator will report the outcome of the investigation to the Deputy Director with responsibility over Behavioral Health-EDC DMC ODS services for concurrence with the investigation outcome.
5. If the outcome of the investigation was not resolved wholly in the Applicant or plan member's favor, the Problem Resolution Coordinator will also report the outcome of the investigation to the Behavioral Health Medical Director, the Mental Health Director, and the Director of Health and Human Services Agency for concurrence with the investigation outcome.

In the event one of the reviewing staff (Deputy Director, Assistant Director, Medical Director, Mental Health Director or the Director of Health and Human Services Agency) do not concur with the investigation outcome, the Appeal will be re-assigned to a different investigator, who will conduct a new investigation.

The Plan shall ensure that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the applicant or plan member or applicant or plan member's authorized representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.

Staff must consider all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

EDC DMC ODS shall provide the applicant or plan member reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. In the case of an Appeal, EDC DMC ODS must inform the applicant or plan member of the limited time available for this sufficiently in advance of the resolution timeframe for an Appeal.

EDC DMC ODS shall provide the applicant or plan member and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by EDC DMC ODS (or at the direction of EDC DMC ODS) in connection with the Appeal of

the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for an Appeal.

An informational document explaining the Grievance and Appeal processes, as well as Grievance and Appeal forms and self-addressed envelopes for submitting such forms shall be available at each of BHD's service sites and each Contracted Provider service sites. These items must be available in English and Spanish and be easily accessible. Clients should not have to ask anyone to obtain these documents.

EDC DMC ODS shall assist the applicant or plan member complete forms and take other procedural steps to file an appeal, including:

- Preparing a written appeal
- Notifying the applicant or plan member of the location of the form on EDC DMC ODS's website or providing the form to the applicant or plan member upon request.
- Advising and assisting the applicant or plan member in requesting continuation of benefits during an appeal of the adverse benefit determination.

Extension of time for processing of appeals

In the event of a delay processing appeals, EDC DMC ODS may request a 14 calendar day extension. EDC DMC ODS shall:

- Provide the applicant or plan member with written notice of the reason for the delay.

- Make reasonable efforts to provide the applicant or plan member with prompt oral notice of the extension.
- Provide written notice of the extension within two (2) calendar days of making the decision to extend the timeframe.
- Notify the applicant or plan member of the right to file a grievance if the applicant or plan member disagrees with the extension.

EDC DMC ODS shall resolve the appeal as expeditiously as the applicant or plan member's health condition requires and in no event extend resolution beyond the 14 calendar day extension. I

NOTE: If EDC DMC ODS fails to adhere to the notice and timing requirements, the applicant or plan member is deemed to have exhausted the appeal process and may initiate a State Hearing.

Expedited appeal resolution

Expedited review of appeals is available when EDC DMC ODS determines (from an applicant or plan member request) or the provider indicates (in making the request on the applicant or plan member's behalf or supporting the applicant or plan member's request) that the 30 day timeframe normally required for resolution could seriously jeopardize the applicant or plan member's mental health or substance use disorder condition and/or the applicant or plan member's ability to attain, maintain, or regain maximum function.

EDC DMC ODS must notify the applicant or plan member, legal representative and/or provider and conduct an expedited review within 72 hours after receipt of a request for expedited review.

If the request for expedited resolution of an appeal is denied, the standard timeframe for resolution shall apply. In such instances, EDC DMC ODS must:

- Log the time and date of appeal receipt when expedited resolution is requested.
- Make reasonable efforts to provide the applicant or plan member with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution;
- Provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the applicant or plan member of the right to file a grievance if the applicant or plan member disagrees with the extension; and
- Resolve the appeal as expeditiously as the applicant or plan member's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within 30 days of receipt of the appeal).

Appeal outcomes and actions

Adverse Benefit Determination Upheld

For appeals not resolved wholly in favor of the applicant or plan member, EDC DMC ODS shall utilize the DHCS template, **Notice of Appeal Resolution (NAR)**. It shall be mailed along with this notice of **Your Rights Under Medi-Cal**. Both notices should be

printed on **El Dorado County Behavioral Health letterhead**.

Adverse Benefit Determination Overturned

For appeals resolved in favor of the applicant or plan member, EDC DMC ODS shall utilize the DHCS template, **Notice of Appeal Resolution (NAR)** on **El Dorado County Behavioral Health letterhead.**

EDC DMC ODS must authorize or provide the disputed services promptly and as expeditiously as the applicant or plan member's condition requires if the decision to deny, limit, or delay services that were not furnished while the appeal was pending is reversed. Authorization or services shall be provided no later than 72 hours from the date and time of the reversal.

All NARs shall include the following information:

- The results of the resolution and the date it was completed;
- The reasons for EDC DMC ODS's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
- For appeals not resolved wholly in the favor of the plan member, the right to request a State hearing and how to request it;
- For appeals not resolved wholly in the favor of the applicant or plan member, the right to request and receive benefits while the State Hearing is pending and how to make the request; and,
- Notification that the plan member may be held liable for the cost of those benefits if the State Hearing decision upholds EDC DMC ODS's adverse benefit

determination.

State Fair Hearing

A State Fair Hearing is an independent review conducted by the State of California to ensure that a plan member receives the services to which they are entitled under the Medi-Cal program and in compliance with the terms of the contract between EDC DMC ODS and DHCS.

Plan members must exhaust EDC DMC ODS appeal process prior to requesting a State Hearing. An applicant or plan member has the right to request a State Hearing only after receiving notice that the plan is upholding an adverse benefit determination.

If EDC DMC ODS fails to adhere to the notice and timing requirements for appeals of adverse benefit determinations, the plan member is deemed to have exhausted the appeals process and may initiate a State hearing.

Governing timeframes

Plan members may request a State Hearing within 120 calendar days from the date of the NAR informing the plan member that the Adverse Benefit Decision has been upheld.

The State must reach its decision within 90 calendar days of the date of the request for the hearing. For expedited hearings, the State must reach its decision within three working days of the date of the request for the hearing.

The parties to State hearing include EDC DMC ODS as well as the plan member and his or her authorized representative or the representative of a deceased plan member's estate.

NOTE: The plan member may, consistent with State policy, be held liable for the cost of Medi-Cal benefits if the State Fair Hearing decision upholds EDC DMC ODS's Adverse Benefit Determination.

Services to the plan member shall continue at the same level they were provided prior to issuance of the Notice of Adverse Benefit Determination during the Appeal or State Fair Hearing process provided the applicant or plan member filed their Appeal or State Fair Hearing within ten (10) calendar days of EDC DMC ODS sending the Notice of Adverse Benefit Determination and:

- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were authorized by EDC DMC ODS.
- The period covered by the original authorization has not expired.

If, at the plan member's request, EDC DMC ODS continues or reinstates the plan member's services while the Appeal or State Fair Hearing is pending, the services must be continued until one of following occurs:

- The plan member withdraws the Appeal or request for State Fair Hearing.
- The plan member fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after EDC DMC ODS sends the Notice of

Resolution to the plan member's Appeal that is adverse to the plan member.

- A State Fair Hearing office issues a hearing decision adverse to the plan member.

If the final Resolution of the Appeal or State Fair Hearing is adverse to the plan member (that is, upholds EDC DMC ODS's Adverse Benefit Determination), EDC DMC ODS may pursuant to its contract with DHCS recover the cost of services furnished to the plan member while the appeal and State Fair Hearing was pending to the extent that they were furnished solely because of the requirements of this policy.

Grievance and Appeal Reporting

EDC DMC ODS's Problem Resolution Coordinator is responsible for:

- Logging and maintaining files related to grievances, appeals and State Fair Hearings.
- Reporting to the Quality Improvement Committee and DHCS information on grievances, appeals and State Fair Hearings.

Grievances, appeals and notices of a State Fair Hearing must be logged within one (1) working day of receipt. The record of each Grievance or Appeal must contain, at a minimum, all of the following information:

- Name of the applicant or plan member
- Date of receipt of the grievance
- Date of acknowledgement of receipt sent
- Nature of grievance

- The date of each review or, if applicable, review meeting.
- Resolution at each level of the grievance or appeal, if applicable.
- Final disposition of a grievance
- Staff representative who received and resolved the grievance.
- Date written decision sent to member
- Documentation of reason that there has not been final disposition of the grievance
- Documentation of appeal or State Fair Hearing Request

The record of grievances and appeals must be submitted quarterly by QA/UR to the Quality Improvement Committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.

Records relating to Grievances, Appeals and State Fair Hearings shall be maintained by EDC DMC ODS for a period of not less than ten (10) years from the final date of the contract then in effect between the State and EDC DMC ODS or from the date of completion of any audit, whichever is later, during which time period the Grievance, Appeal or State Fair Hearing was received and resolved. These records will be available for review by the State, Centers for Medicare & Medicaid Services, the Office of the Inspector General, the Comptroller General, and their designees, at any time.

DHCS quarterly reporting

The Problem Resolution Coordinator shall prepare the mandated DHCS **Grievance and Appeal Log** (Excel worksheet) using the **instructions provided by DHCS**. QA/UR reviews submits the log to DHCS 15 calendar days after the end of each quarter per the filing schedule in the DHCS instructions unless otherwise stipulated by DHCS.

REFERENCE

DHCS MHSUDS INFORMATION NOTICE 18-010E; 2 Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F; Title 42, CFR, Section 438.400(b); Title 42, CFR, Section 438.408(b) and (c); Title 42, CFR, Section 438.404(b); Title 42, CFR, Section 438.408(c)(3); Title 42, CFR, Section 431.211; Title 42, CFR, Sections 438.402(c)(3)(ii) and 438.406(b)(3); Title 28, California Code of Regulations (CCR), Section 1300.68(a); Title 42, CFR, Section 438.10(b)(4)(ii)