	County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM-03-01**
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Title: **Problem Resolution**		Functional Area: **Beneficiary Protection**	
Approved by: (Signature on File) **Signed version available upon request** **Alexandra Rechs, LMFT** Program Manager, Quality Management			

BACKGROUND

In accordance with California Code of Regulations Title 9, Chapter 11, Federal Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Regulations (CFR), Chapter IV, Subchapter C, Part 431, Subpart E; Part 438, Subpart C and Subpart F, the Division of Behavioral Health Services (BHS), which includes the Sacramento County Mental Health Plan (MHP), and the Sacramento County Drug Medi-Cal Organized Delivery System (DMC-ODS) within the Substance Use Prevention and Treatment program (SUPT) desires to ensure that beneficiaries of the plan (also referred to as members) and providers have access to a process for the resolution of grievances and appeals. All concerns about services will be addressed in a sensitive, timely, and culturally competent manner. Member rights will be protected at all stages of the grievance and appeal process. Quality Management Services (QM) will be responsible for monitoring member dissatisfaction and provider concerns, privacy issues, grievances, appeals and applicable Mental Health Services Act (MHSA) related issues. All written communications with members and providers will be written in clear, concise language in a format understandable to the member. The QM Problem Resolution staff and Beneficiary Protection Coordinator will be available to assist in resolving grievances, appeals, State Fair Hearings (SFH), or related processes.

This policy also provides guidance for issues related to the Mental Health Services Act (MHSA) implementation, including but not limited to, issues related to the appropriate use of funds, local community program planning process, and inconsistency between an approved plan and program implementation. The attached MHSA Issue Resolution Process details the process by which applicable MHSA issues will be addressed.

DEFINITIONS

ADVERSE BENEFIT DETERMINATION: An adverse benefit determination occurs when the MHP or SUPT does any of the following: denies or limits authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; reduces, suspends, or terminates a previously authorized service; denies, in whole or part, payment for a service; fails to provide services

in a timely manner, as determined by the MHP or SUPT, or fails to act within the timeframes for disposition of grievances, the resolution of standard appeals, or the resolution of expedited appeals; or denies a disputed financial liability, including, but not limited to, cost sharing, copayments, premiums, deductibles, and coinsurance.

CONSUMER ADVOCATE: An advocate provided through the MHP or SUPT who is available to help members through the grievance/appeal process by representing the member's point of view. Sacramento County's MHP and SUPT has designated two advocates, one specializing in assistance to adult members and one specializing in assistance for children and families.

COMPLAINT BY PROVIDER: A provider complaint is a statement registered by a provider about a problem that can be resolved informally. These problems may include, but are not limited to, appointment scheduling, inappropriate referrals, denial of service, cultural issues, change of provider issues, etc.

CONTINUITY OF CARE: Beneficiaries with pre-existing provider relationships, who make a request to the Sacramento County MHP for continuity of care services, will be given the option to continue services for a period not to exceed 12 months with an eligible out-of-network Medi-Cal provider or a terminated network provider in order to complete a course of treatment or to arrange for a safe transfer of services.

DISCRIMINATION: The MHP and SUPT complies with applicable Federal civil rights laws and does not discriminate against, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

EXPEDITED APPEAL: An expedited appeal is an oral or written request to review an adverse benefit determination and is to be used when using the standard resolution process could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

GRIEVANCE BY BENEFICIARY (MEMBER): A grievance is defined as any expression of dissatisfaction about any matter other than an adverse benefit determination by a member, verbally or in writing or, with the member's permission, by a support person such as family, friend, or advocate, regarding services offered through the MHP or SUPT. Examples of possible grievances include, but are not limited to the quality of care or service, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect a member's rights, barriers accessing services, etc.

MENTAL HEALTH PLAN (MHP): Sacramento County is the entity responsible for the oversight and implementation of Managed Care Medi-Cal Specialty Mental Health Services for Sacramento County and the Mental Health Services Act. All County providers, contract organizational providers, and network providers are Providers for the MHP. All consumers who receive services under the MHP are the members.

MENTAL HEALTH SERVICES ACT (MHSA) ISSUE: A MHSA issue is defined as any expression of dissatisfaction about any matter related to the MHSA. MHSA issues will follow the MHP policy for beneficiary issue resolution. Examples of possible issues include, but are

not limited to, the appropriate use of MHSA funds, Sacramento County community program planning processes, and inconsistency between approved plan and program implementation. (See attached MHSA Issue Resolution Process)

PRIVACY ISSUE (HIPAA): A form of grievance specifically regarding protected health information (PHI) as it pertains to concerns about a provider's policies and procedures, misuse, denial of access, or denial to change the members protected health information.

PATIENTS' RIGHTS ADVOCATE: The person(s) designated in Welfare and Institutions Code, Section 5500 et seq. to advocate for and protect the rights of all recipients of mental health services. Patient Rights advocacy services are provided in Sacramento County through a contract with the Consumer Self-Help Center.

PROBLEM RESOLUTION STAFF AND COORDINATOR: The Quality Management Problem Resolution staff qualify as Licensed Practitioner of the Healing Arts (LPHA), and have the appropriate level of clinical expertise in treating mental health conditions or diseases. They are responsible for analyzing, investigating, and resolving grievances, appeals and State Fair Hearings, while taking into account all comments, documents, records, and other information submitted by the beneficiary, or their representative, without regard to whether such information was submitted or considered previously. They explain the grievance process and mediate disputes and/or resolve grievances and appeals at the lowest level whenever possible. Upon request, the staff can assist the member with filing a grievance, appeal or a State Fair Hearing. The Problem Resolution staff will provide the member with information on the status of his/her appeal or grievance. The Problem Resolution staff will only be involved in one level of review or decision making for each grievance or appeal, and will not be the subordinate of the staff involved in a previous level of a grievance or appeal, if applicable.

STANDARD APPEAL A standard appeal is an oral or written request to review an adverse benefit determination. Oral appeals must be followed up with a written, signed appeal. There is only one level of appeal.

STATE FAIR HEARING: A formal hearing conducted by the State Department of Social Services as described in Code of Federal Regulations, Title 42, Part 431, Subpart E et seq. A member may file for a State Fair Hearing after receiving notice that the adverse benefit determination is upheld. The Administrative Law Judge who presides over the Hearing has authority over those issues related to an adverse benefit determination.

SUBSTANCE USE PREVENTION AND TREATMENT (SUPT): Sacramento County is the entity responsible for the oversight and implementation of the Managed Care Plan for the Drug Medi-Cal Organized Delivery System (DMC-ODS) for Sacramento County members. SUPT is the name of Sacramento County's Plan. All drug and alcohol county providers, contract organizational providers, and network providers are Providers for SUPT.

PURPOSE

The purpose of this policy is to delineate policies and procedures for the resolution of member privacy issues, grievances, appeals and applicable issues related to MHSA. The problem resolution process will focus on resolution of a member's concern and provider problems in the most simple and prompt manner possible. Sacramento County will mediate and handle disputes at the lowest possible level. The means for notifying members and providers about these processes, and the procedures for making them available will be addressed. The roles and responsibilities of BHS, beneficiaries (members) and providers will be specified. BHS will not discriminate or penalize a beneficiary or provider for using the grievance or appeal process.

DETAILS

GENERAL PROVISIONS

1. Members may appoint a representative (family member, friend, support person, provider, or provider staff) to act on their behalf. A consent to release information must be signed for the representative to receive confidential information. Parents or guardians, parent advocates, foster parents, or social service workers with responsibility for W & I Code 300 dependents may act as a representative of a minor, unless otherwise provided by law.
2. The Grievance and Appeal processes do not replace the duties of the County Patient Rights Advocate. Members will be encouraged to consult with the Patient's Rights Advocate whenever they need additional assistance to resolve their issues, or if they have questions regarding their legal rights under Lanterman-Petris-Short Act (LPS) law. Problem Resolution staff will work closely with Patient Rights, whenever indicated. A consent to release information must be signed for Patient's Right staff to receive confidential information.
3. All processes for problem resolution will maintain the confidentiality of the member in accordance with applicable State and Federal laws. The necessary consent for release of information will be obtained whenever information about a member is to be exchanged with a third party.
4. Grievance information shall not be maintained in the client's medical record or scanned into the electronic health record. Grievance information will be stored in a secure file cabinet with limited access at the Provider's or Problem Resolution office site to ensure that only authorized personnel have access to grievance information.
5. Members will not be subject to discrimination or any other penalty for filing a grievance, an appeal, a State Fair Hearing, or reporting concerns relating to a privacy issue.
6. Grievance procedures will be considered high priority for members in Medi-Cal funded residential treatment programs when the grievance is received by the MHP or SUPT prior to the member's discharge from the service. The grievance process for Medi-Cal funded residential treatment programs will be client friendly and timely, in recognition of the danger some psychiatric conditions represent to members. Services will continue pending the resolution of the grievance.
7. When a concern is identified regarding an employee's practices or performance as a result of a grievance or appeal, this will be addressed by the employee's supervisor in accordance with that entity's (County or provider) personnel policies and procedures. Quality Management, however, will reserve the right to generalize the specific instance to a more global issue (e.g., client confidentiality, etc.) and request that the provider provide a general staff training in that area.

8. Members will be notified in writing within 15 days after receipt or issuance of a provider termination notice.

ACCESSIBILITY OF THE PROBLEM RESOLUTION PROCESS

NOTIFICATION: When the member first accesses services, and annually thereafter for continuing clients, members will be informed both verbally and in writing of the process for reporting and resolving grievances and appeals. This information will also be available through the 24-hour response line. The Members Rights and Problem Resolution Brochure and the MHP and SUPT Member Handbooks will state that a State Fair Hearing may be filed, following an adverse benefit determination, only after the member receives notice that the adverse benefit determination has been upheld by the MHP or SUPT. The handbooks and brochures will include information on how to contact the Problem Resolution staff and will be available at all sites where members receive services. All provider sites will provide the grievance forms as either a self-addressed form or with self-addressed envelopes for mailing by the beneficiary. Each provider will have a grievance/suggestion box accessible to members. Notices of grievance and appeal procedures, including the right to request a State Fair Hearing (i.e., the Problem Resolution poster), grievance and appeal forms, and grievance brochures will be readily accessible and visibly posted in prominent locations in client and staff areas including client waiting areas, without a member having to make a request. Providers will be informed at the time of contracting, and at regularly scheduled Quality Management trainings, of the problem resolution process and the above requirements and expectations.

LANGUAGE ACCESSIBILITY: Sacramento County has identified threshold languages, including English, for the MHP and SUPT service areas. All providers are expected to have, at a minimum, the Problem Resolution Poster, Member Handbook, and the Grievance/Appeal Brochures available, upon request, and readily accessible in all threshold languages. All providers are encouraged to recruit and employ staff with language capacity for the needed languages. At a minimum, every provider must have a means to access interpreter services when needed. This may be done through local specialty providers, the Language Line, or private contracts with professional interpreters. All points of access to the MHP and SUPT services, including the 24-hour after-hours line, will also secure and use interpreter services as needed, with the goal of providing services that are customer friendly, culturally competent, and as seamless as possible. The QM Problem Resolution staff will also use interpreter services as necessary for the problem resolution process. Language accommodations will be available to the member at no cost.

SPECIAL NEEDS ACCESSIBILITY: All Points of access and all providers will have familiarity with the California Relay Service, and the sign language interpreter services provided by the local office of NorCal in order to assist members with hearing impairments. A few provider sites also have staff with Sign Language capability. Services for members with visual impairments will be provided by orally reading relevant material to the member, or providing the member with materials in large print or an audio format of the member handbook. For those members whose functional literacy may be insufficient for the reading level of the materials, provider staff will also read the material orally to the member or provide

an audio format of the member handbook. The offer to do so will be made in a sensitive and respectful manner, upon request, and at no cost to the member.

ROLES AND RESPONSIBILITIES OF THE MENTAL HEALTH PLAN (MHP)

1. The Mental Health Plan and Substance Use Prevention and Treatment delegates to Quality Management (QM), Member Services the responsibility of monitoring member dissatisfaction, change of provider requests, privacy issues and accomplishing the following objectives:
    a. Insure that procedures are in place to inform members of the process for initiating a grievance or appeal.
    b. Monitor actions to resolve grievances and appeals.
    c. Review and track grievances and appeals on a regular basis to identify patterns, trends, and system issues affecting quality of care.
    d. Report findings to the MHP Quality Improvement Committee on a regular basis.
    e. Develop action plans to address identified quality of care issues.

2. Quality Management will identify specific employees to serve as the Problem Resolution staff. The Problem Resolution staff will perform the following primary functions:
    a. Assist members to report privacy issues, request a change of provider, file a grievance or appeal, or request a State Fair Hearing, when necessary.
    b. Explain the privacy issue or grievance/appeal process upon request and as pertinent when assisting a member.
    c. Investigate, analyze, and resolve appeals and grievances received by Member Services, and serve as the initial reviewer at the first point of entry into the problem resolution process. If an appeal handled by the Problem Resolution staff is submitted more than once, the Problem Resolution staff will refer the matter to a QM Program Coordinator in order to promote unbiased review.
    d. Investigate/report to the appropriate provider agency or QM privacy officer, to the extent possible, any anonymous reports of alleged HIPAA violations.
    e. Mediate disputes and resolve problems at the lowest level whenever possible.
    f. Work with members, identified representatives, providers, contract monitors, and the Patient Rights and Consumer/Child and Family Advocates, as applicable, to mediate satisfactory resolutions whenever possible.
    g. Provide information to the member on the status of his/her appeal or grievance.
    h. Provide written notification of the resolution decision to all affected parties.
3. The Problem Resolution staff will maintain a Grievance/Appeal Log documenting privacy issues, grievances, appeals, change of provider requests, requests for a State Fair Hearing and a MHSA Issue Log documenting applicable MHSA Issues. All appeals and grievances concerning mental health services will be recorded in the Grievance/Appeal Log *within one working day of the date of receipt*. The log entry will include the following information:
    a. The name of the member (beneficiary).
    b. The date of receipt of the appeal or grievance.
    c. A general description of the reason for the appeal or grievance.

d. The date of each review or, if applicable, review meeting.
e. Resolution of each appeal or grievance.
f. date of final resolution of the appeal including the date the decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final resolution of the appeal.

4. The Problem Resolution staff will acknowledge the receipt of each grievance or appeal in writing. This standard is not required for the expedited appeals. If the expedited appeal is denied, the staff will give prompt oral notification and send written notification to the beneficiary within two calendar days.
5. The Problem Resolution Program Coordinator will submit a report summarizing the number of grievances, appeals and State Fair Hearings, the nature of the problems, and the outcomes to the Quality Improvement Committee on a quarterly basis. This report will be submitted to DHCS annually for the MHP and quarterly for SUPT.
6. Quality Management will develop and make available on the County website Beneficiary Protection materials. These materials will be available in all of the threshold languages identified for the Sacramento County service area.
7. Quality Management will monitor the display and accessibility of problem resolution materials, including the required threshold languages and taglines, at the provider sites by means of the certification review process and informal monitoring whenever any Quality Management staff person has occasion to visit a provider site.
8. Quality Management will offer regularly scheduled training to educate providers about the problem resolution process, requirements and expectations.
9. Quality Management, upon receiving notification of a provider termination, will determine the process for notifying affected members.

ROLES AND RESPONSIBILITIES OF THE PROVIDER

1. All service providers will be knowledgeable about the problem resolution process and be able to answer questions, assist members in understanding their rights, and assist members to file a grievance, appeal or State Fair Hearing, as requested.
2. All service providers will designate a point of contact for Problem Resolution and notify the Problem Resolution Coordinator.
3. All service providers will be knowledgeable regarding privacy issues as detailed in the Healthcare Insurance Accountability Act (HIPAA). Providers will assist their members in understanding their rights, and assist members to file a grievance with the appropriate Privacy Officer and/or the U.S. Department of Health and Human Services, Office of Civil Rights.
4. All service providers will designate a Privacy Officer and advise the Quality Management Privacy Officer.
5. Providers will give each member a copy of the Problem Resolution Brochure, Provider Notice of Privacy Practices, and Voter Registration information (mental health providers only), when the member first accesses services with their assigned provider, and annually thereafter. Providers will give each member the Advance Medical Directive when the member first accesses services with their assigned provider, and upon request. The Provider will give each member a copy of either the Guide to Medi-Cal Mental Health Services Member Handbook or Drug Medi-Cal Organized Delivery System Member Handbook and Provider List when the member first accesses services with their assigned

provider, and upon request, either in writing or by directing them, in writing, to the Sacramento County website. This will be evidenced by the Member's signature on the Acknowledgment of Receipt form.

6. Providers will have on display and readily available to members the Problem Resolution Guide, privacy rights, appeal and grievance forms and change of provider request forms in all of the identified threshold languages, along with applicable taglines. Members will not be required to make a verbal or written request for these materials. The Problem Resolution Poster(s) will be posted in a prominent and visible location that members can freely access, such as the lobby or in waiting areas.
7. Providers will provide a suggestion/grievance box in an area members can freely access such as the lobby or waiting area of the provider site.
8. Providers will maintain a log book to track and resolve beneficiary issues presented to the agency for internal resolution. The log will contain the date the issue was presented, member's name, nature of the problem, and disposition. All issues will be logged within one working day from the date of receipt of the issue and will be resolved within (30) calendar days.
9. Providers will submit an annual summary report and analysis of the issues handled at the provider site to the Quality Management Unit. The report will be due by September 1st of each year and reflect information from the previous fiscal year beginning July 1st and ending June 30th.
10. Providers will respond promptly to the Problem Resolution staff in the investigation and resolution of appeals, privacy issues, grievances, requests for change of provider, and State Fair Hearings.
11. Providers will notify the MHP or SUPT Program Manager, as soon as possible, following the decision to terminate mental health and alcohol and drug services provided.
12. The Problem Resolution staff is available for consultation to the provider, upon request.

ROLES AND RESPONSIBILITIES OF MEMBERS

1. Members must provide Medi-Cal eligibility information when requesting mental health or alcohol and drug services.
2. Members must participate in an initial assessment to determine medical necessity for MHP or SUPT services.
3. The MHP and SUPT encourages members to participate in their treatment planning, to evaluate the services received, and to offer suggestions to improve services.
4. Members are entitled to the following rights:
    a. Be treated with respect and with due consideration for his or her dignity and privacy.
    b. Receive culturally sensitive services that meet the member's language needs.
    c. Use of an interpreter at no cost to the beneficiary.
    d. Services provided in a safe environment.
    e. Protection of personal health information.
    f. Request and receive a copy of his or her medical records, and request that they be amended or corrected.
    g. Participate in treatment planning and decisions regarding his or her mental health or alcohol and drug services, including the right to refuse treatment.

h. Receive information on available treatment (including medications) options and alternatives, presented in a manner appropriate to his or her condition and ability to understand.
i. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
j. Request a second opinion, a change of therapist/provider, and/or change in level of care.
k. Staff consideration of a problem or concern about services.
l. File a grievance or appeal regarding services.
m. File a State Fair Hearing following an adverse benefit determination after the member has exhausted the MHP or SUPT appeal process.
n. Delegate a person to act for them during the appeal, grievance, or State Fair Hearing process.
o. File an appeal, grievance, or request a State Fair Hearing without penalty of any kind.
p. Have family members or advocates talk to the provider about the member's treatment, with the member's written permission.
q. Receive written information on MHP or SUPT benefits, Problem Resolution process, Provider Lists and Advance Medical Directive.

GRIEVANCE PROCESS

GRIEVANCE: It is the intent of the MHP and SUPT that expressions of dissatisfaction about mental health or alcohol and drug services be resolved as quickly and simply as possible and agreeable to the member, whenever possible.

1. A Grievance can be filed verbally or in writing, at any time. The member can authorize a representative to act on his/her behalf. Consent to release information must be signed for the representative to receive confidential information.

2. The Problem Resolution staff must log grievances within (1) one working day of the date of receipt of the grievance. Log must include at least; member name or identifier; date of grievance receipt; general description of the reason for the grievance; the date of each review or, if applicable, review meeting, the resolution at each level of the grievance, if applicable, and, date of the grievance resolution at each level, if applicable.

3. The Problem Resolution staff will send a written acknowledgment receipt of the grievance to the member, which notifies the member of the timeframe for the resolution of a grievance.

4. The Problem Resolution staff will provide a reasonable opportunity for the member to present evidence, and allegation of fact or law, in person as well as in writing.

5. The Problem Resolution staff investigates and analyses the issue(s) and develops a plan for resolution.

6. A decision on a grievance will be rendered within (90) ninety calendar days of receipt of a grievance. The decision will be in writing with copies forwarded to the member, or their authorized representative, and the involved service provider(s). If there is not

a final resolution of the grievance, there will be documentation of the reason(s) for such an outcome in the case notes.

7. The timeframe may be extended by up to (14) fourteen days in certain circumstances. The Problem Resolution staff will make reasonable efforts to give the member prompt oral notice of the delay and resolve the grievance as expeditiously as the member's health condition requires, and no later than the date the extension expires.
8. If the extension was not requested by the member a written notice will be sent to the member stating the reason for the delay within (2) calendar days.
9. The reason for an extension will be documented in the case notes. The documentation must show that there is need for additional information and how the delay is in the member's interest.

PRIVACY ISSUE

It is the intent of the MHP and SUPT that grievances concerning private health information be processed and resolved at the lowest level possible and agreeable to the member, whenever possible.

1. Member reports of privacy violations or concerns will be entitled to the same process and rights of the problem resolution process. (See Grievance Process)
2. Member reports of privacy violations or concerns will be documented and sent to the provider agency's Privacy Officer and notification will be sent to the Quality Management Deputy Privacy Officer.
3. Member will be given a written statement regarding the outcome of the grievance.
4. Member will be given information regarding the process to file a complaint with the appropriate HIPAA Privacy Officer and the US Department of Health and Human Service, Office of Civil Rights.

CHANGE OF PROVIDER

The MHP and SUPT strive to honor a member's right to change providers whenever possible. Members may request to change providers directly through their current provider, by contacting the MHP Access Team or SUPT System of Care, or by contacting QM Member Services. There are two types of member Change of Provider requests: (1) a request to change to a different staff member within the same provider agency or (2) a request to receive services from a different outpatient provider agency.

1. A member may request a Change of Provider, when initiating services and at any time thereafter.
2. Change of Provider requests can be made verbally or in writing using the Change of Provider form.
3. The member may appoint a representative to act on his/her behalf.
4. Change of Provider requests will be logged and resolved within (90) ninety calendar days.
5. The Problem Resolution staff will review the request by interviewing the member and provider as to the circumstances prompting the request.
6. In resolving requests to Change Providers, QM Member Services will consider the following factors

- Availability of resources.
- Culture-specific needs.
- Level of care requested.
- Reason for the request.
- Resources of the member (e.g., transportation).
- Member's utilization of services/involvement at a site (e.g., working as a volunteer).
- Available options within the provider site.
- Whether the request involves a service option or activity available at the site requested, but not at the current or geographic site.
- Appropriateness

CONTINUITY OF CARE

At any time, eligible beneficiaries, who meet specialty mental health criteria, may change their provider from an out-of-network provider to the Sacramento County MHP, whether or not a continuity of care relationship has been established. However, beneficiaries with pre-existing provider relationships, who make a request to the Sacramento County MHP for continuity of care services, will be given the option to continue services for a period not to exceed 12 months, with an eligible out-of-network Medi-Cal provider or a terminated network provider, in order to complete a course of treatment or to arrange for a safe transfer of services, under certain conditions (see Continuity of Care P&P for additional details).

PROVIDER TERMINATION

It is the intent of the MHP and SUPT to provide to affected members written notification of termination of a contracted provider's services within (15) days after receipt or issuance of the termination notice.

1. Depending on circumstances, the MHP, SUPT or the provider will send a letter to each affected member of the impending termination of their service provider.
2. The MHP or SUPT may send a letter on behalf of the provider.
3. If the provider sends the letter, the MHP or SUPT Program Manager will review and approve the letter prior to mailing.
4. The MHP or SUPT will ensure that access points to its services are informed of the change and provider directories are updated appropriately.
5. The letter will specify the expected date of closure and a copy will be forwarded to Quality Management or SUPT Management, the appropriate Access Team and program staff.
6. The letter will provide the members with information regarding referrals within the community to the extent resources are available.
7. QM or SUPT will update the applicable Medi-Cal provider list and notify all other administrative components affected by the change.

ADVANCE DIRECTIVES

It is the intent of the MHP and SUPT to provide information to the member regarding their right to have an Advance Medical Directive. (See Advance Medical Directive Policy and Procedure, QM P & P)

1. Member's expressed concerns regarding the Advance Medical Directive requirements will be entitled to the same process and rights of the Problem Resolution process (see Grievance).
2. The Member will not be subject to discrimination and the decision to have an executed Advance Medical Directive or not will not interfere with the provision of their mental health or alcohol and drug services.
3. Problem Resolution staff will inform members that complaints concerning noncompliance with the Advance Medical Directive requirements may be filed with the California Department of Health Services Licensing and Certification by calling 1-800-236-9747 or by mail at P.O. Box 997413, Sacramento, Ca. 95899-1413.

VOTER REGISTRATION

It is the intent of the MHP to offer voter registration to each qualified beneficiary at the start of service and yearly thereafter. The member's preference will be documented on the Voter Preference Form and placed in his/her record for two years.

1. Applying to register or declining to register to vote will **not** interfere with the provision of mental health services. All information will be kept confidential.
2. Providers may assist the member with filling out the voter registration application form, making a name change or address change.
3. Providers may **not** influence a member's political preference, display any political preference or party allegiance, or make statements which might discourage the member from registering to vote.
4. If a member believes someone has interfered with his/her right to register, or to decline to register to vote or his/her right to privacy in deciding whether to register, or in applying to register to vote, or their right to choose their own political party preference, the member may file a complaint with the Secretary of State.

   Toll free (800)345-VOTE (8683) or Write:
   Secretary of State
   1500 11th Street
   Sacramento, CA 95814
   www.sos.ca.gov

APPEAL PROCESS

STANDARD APPEALS

1. A member may request a Standard Appeal orally or in writing. Oral appeals must be followed up with a written, signed appeal. However, the date that the member submitted the oral appeal is the filing date.
2. The member must file an appeal within (60) sixty calendar days of the date of the Notice of Adverse Benefit Determination.
3. The Problem Resolution staff must log appeals within (1) one working day of the date of receipt of the appeal. The log must include at least; member's name or identifier; date of appeal receipt; general description of the reason for the appeal; the date of each

review or, if applicable, review meeting, the resolution at each level of the appeal, if applicable, and date of the appeal resolution at each level, if applicable.

4. The Problem Resolution staff will send a written acknowledgment receipt of the appeal to the member, which notifies the member of the timeframe for resolution of an appeal.
5. Members may appoint a representative (family member, friend, support person, provider, and staff) to act on his/her behalf. A consent to release information must be signed for the representative to receive confidential information.
6. The Problem Resolution staff will not have been involved in any previous level of review or decision-making; and, if the decision is clinical in nature (as defined), the staff must be a health care professional with the appropriate clinical expertise in treating the member's condition.
7. The Problem Resolution staff will provide a reasonable opportunity for the member to present evidence, and allegation of fact or law, in person as well as in writing.
8. The Problem Resolution staff will notify the member and/or an appointed representative that s/he has the right to examine, and receive copies of, the medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP or SUPT (or at the direction of the Plan) in connection with the appeal of an adverse benefit determination, free of charge and sufficiently in advance of the resolution timeframe for appeals.
9. A decision will be rendered within (30) thirty calendar days of receipt of an appeal. The member, and/or the authorized representative, will receive the decision in writing with copies forwarded to the provider, when applicable. The notice must contain: The results of the appeal resolution process and the date that the appeal decision was made. The appeal process has only one level of appeal, therefore, if the appeal is not resolved wholly in favor of the member, the notice must also contain the member's right to a State Fair Hearing and the procedure for filing a State Fair Hearing. The member may continue to receive services and benefits while the hearing decision is pending, under certain conditions.
10. The timeframe may be extended by up to (14) fourteen days in certain circumstances. The Problem Resolution staff will make reasonable efforts to give the member prompt oral notice of the delay and resolve the appeal as expeditiously as the member's health condition requires, and no later than the date the extension expires.
11. If the extension was not requested by the member a written notice will be sent to the member stating the reason for the delay within (2) calendar days.
12. The reason for an extension will be documented in the case notes. The documentation must show that there is need for additional information and how the delay is in the member's interest.

EXPEDITED APPEAL PROCESS

An expedited appeal is used when using the standard resolution process could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

1. An expedited appeal may be presented orally or in writing to request a review of an Adverse Benefit Determination. If an expedited appeal is received orally, the beneficiary is not required to also submit a written appeal.
2. Acknowledgment of receipt is not required for an expedited appeal unless it is denied by the Problem Resolution staff. If the expedited appeal is denied, every effort will be

made to give prompt oral notification and follow up within (2) calendar days with a written notice. The appeal will then be transferred to the standard appeal timeframes.

3. The Problem Resolution staff must log appeals within (1) one working day of the date of receipt of the appeal. Log must include at least; beneficiary name or identifier; date of appeal receipt; general description of the reason for the appeal; the date of each review or, if applicable, review meeting, the resolution at each level of the appeal, if applicable, and, date of the appeal resolution at each level, if applicable.
4. The Problem Resolution staff will not have been involved in any previous level of review or decision-making. If the decision is clinical in nature the staff must be a Licensed Practitioner of the Healing Arts (LPHA) with the appropriate clinical expertise in treating the beneficiary's condition.
    a. A Program Coordinator independent of the Problem Resolution process with expertise in the operations of the MHP or SUPT will review the request for an expedited appeal. The decision to process the request or deny the expedited status will be forwarded to the Problem Resolution Staff.
    b. The Problem Resolution staff will provide a reasonable opportunity for the beneficiary to present evidence, and allegation of fact or law, in person and/or in writing. The staff will inform the member of the limited time available for the expedited resolution.
5. The Problem Resolution Staff will notify the member and /or an appointed representative (with appropriate release of information) that s/he has the right to request, and receive copies of, the member's medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP or SUPT (or at the direction of the Plan) in connection with the appeal of the adverse benefit determination, free of charge and sufficiently in advance of the resolution timeframe for appeals.
6. The Problem Resolution staff will resolve the appeal and notify the beneficiary, or the authorized representative, orally and in writing of the decision no later than 72 hours after the appeal is received. Involved service providers will also receive a copy of the written notification, when applicable. The notice must contain the results of the appeal resolution process and the date that the appeal decision was made. The appeal process only has one level of appeal therefore, if the appeal is not resolved wholly in favor of the member, the notice must also contain the member's right to a State Fair Hearing and the procedure for filing for a State Fair Hearing. The member may receive benefits while the hearing is pending, under certain conditions.
7. This timeframe may be extended up to fourteen (14) days in certain circumstances. The Problem Resolution staff will make reasonable efforts to give the member prompt oral notice of the delay and resolve the appeal as expeditiously as the member's health condition requires, and no later than the date the extension expires.
8. If the extension was not requested by the member a written notice will be sent to the member stating the reason for the delay within (2) calendar days.
9. The Problem Resolution staff will document the reason for an extension in the case notes. The documentation must show that there is need for additional information and how the delay is in the member's interest.

STATE FAIR HEARING

1. A member may request a State Fair hearing after receiving an appeal notification from Problem Resolution staff that the Notice of Adverse Benefit Determination was upheld.
2. A member may also request a State Fair hearing when the MHP or SUPT fails to adhere to the notice and timing requirements. In this case, the member is deemed to have exhausted the MHP or SUPT appeals process.
3. The request for a State Fair hearing may be no later than (120) calendar days from the date of the MHP or SUPT notice of appeal resolution.
4. A request for a State Fair Hearing may be made in writing to the State Hearing Division, California Department of Social Services, P.O. Box 944243, Mail Station 19-37, Sacramento, CA 94244-2430, or by telephone to 1-800-952-8349.
5. The member must request continuation of mental health or alcohol and drug services within ten (10) days of the postmark date of the Notice of Adverse Benefit Determination or before the effective date of the change, whichever is later, in order for the services to continue at the same level while the hearing is pending.
6. The Department of Health Care Services will notify the Problem Resolution staff when a member has made a request for a State Fair Hearing. The Problem Resolution staff will log the request within one working day of receipt.
7. If Problem Resolution staff is successful in resolving the concern prior to the hearing date, the member can be requested to sign an ***Unconditional Withdrawal*** of the Request for a State Fair Hearing. If the withdrawal is conditional, a written agreement will be signed by the beneficiary and the County. The member has thirty (30) calendar days to rescind a ***Conditional Withdrawal***. The Problem Resolution staff should verbally inform the County Administrative Hearing Officer of the withdrawal.
8. Prior to each hearing, Problem Resolution staff will prepare a Statement of Position using the standard format required for the hearing. A copy of the Statement of Position is to be provided to the member and his/her authorized representative not less than two (2) working days prior to the scheduled date of the hearing. The State Fair Hearing decision is final.
9. The State may offer and arrange for an external medical review if the following conditions are met: the review must be at the member's option and must not be required before or used as a deterrent to proceeding to the State Fair Hearing; the review must be independent of the MHP or SUPT. The review must be offered without cost to the member. The review must not extend the timeframes of appeal and must not disrupt the continuation of benefits.
10. If the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MHP or SUPT must authorize or provide the disputed services no later than 72 hours from the date of notice of reversing of the Adverse Benefit Determination.
11. If the State Fair Hearing officer reversed a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MHP or SUPT must pay for those services, in accordance with State policy and regulations.

PROVIDER GRIEVANCE

A Provider grievance is defined as any expression of dissatisfaction about any matter other than an appeal concerning a denied or modified request for MHP or SUPT payment authorization or the processing of the payment of a provider's claim.

1. The provider initiates the Provider Problem Resolution Process by submitting orally or in writing a statement identifying the issue or concern.
2. The Problem Resolution staff will acknowledge the written or oral statement within (3) business days of its receipt. Problem Resolution staff will initiate resolution activities.
3. If the grievance concerns a denied or modified request for MHP or SUPT payment authorization or the processing of payment of a provider's claim, the provider will be informed of their right to the Provider Appeals Process at any time during or after the Problem Resolution Process.
4. When a provider of mental health or alcohol and drug services has an issue regarding authorization of services, the provider is encouraged to contact the Access Team Program Coordinator as a part of the MHP's or SUPT's efforts to resolve issues in the most timely and expeditious manner. .
5. The Problem Resolution staff will review and track all aspects of the issue(s) and respond to the provider within (60) calendar days, in writing, of the decision.

PROVIDER APPEAL

A provider appeal is defined as dissatisfaction with a denied or modified request for MHP or SUPT payment authorization.

1. The provider may contact the Behavioral Health Director or designee to request review and resolution of the issue. The designee for Provider appeals is the QM Manager. The Quality Improvement Committee may serve as the body to review the Provider Appeal.
2. If the appeal concerns the denial or modification of a MHP or SUPT payment authorization request, personnel not involved in the initial denial or modification decision will make a determination on the appeal. If the appeal concerns the denial of an inpatient hospitalization based on medical necessity, a physician, not involved in the original denial, will review the appeal.
3. The MHP or SUPT will have (60) calendar days from the receipt of the appeal to inform the provider, in writing, of the decision. If the MHP or SUPT does not respond within the (60) days, the appeal will be considered a denial.
4. If the appeal is not granted in full, the provider will be notified of their right to submit an appeal to the Department of Health Care Services.
5. The provider may submit a revised request within (30) calendar days from receipt of the MHP or SUPT decision.
6. The MHP or SUPT will have (14) calendar days from the date of receipt of the provider's revised request to inform the provider of the decision.
7. If the MHP or SUPT does not respond within (60) days to a revised appeal, the revised appeal is considered denied in full by the MHP or SUPT.

PROVIDER APPEALS TO THE DEPARTMENT OF HEALTHCARE SERVICES (DHCS)

A provider seeking to appeal directly to DHCS regarding a MHP or SUPT provider issue, must provide the MHP or SUPT notification of this action at the same time that the appeal is sent to DHCS. The MHP or SUPT will respond to requests for follow up actions from DHCS regarding such appeals and provide appropriate documentation and substantiation of efforts to resolve disputes at the local level. The MHP or SUPT will follow state guidelines to address this process.

INPATIENT APPEALS

1. In the event the dispute cannot be resolved, the provider may submit an appeal to the Department of Health Care Services (DHCS) under the following circumstances:
    a. Appeal concerns the denial or modification of a MHP payment authorization request for specialty mental health services provided for an emergency admission to a psychiatric inpatient hospital, Fee for Service/Medical hospital, or psychiatric health facility and was denied in full or in part by the MHP Provider Appeal Process on the basis the provider did not comply.
        1) Required timelines for notification or submission of the MHP payment request.
        2) Medical necessity was not met.
        3) Requirements for administrative days were not met.
2. A hospital may not appeal the denial or modification of the MHP payment authorization to DHCS when the denial is based on the MHP's determination that a hospital has failed to comply with mandatory provisions of the contact between the provider and the MHP.
3. The provider must submit an appeal to DHCS in writing, along with supporting documentation, within (30) calendar days from the date the MHP's written decision of denial or modification was submitted to the provider.
4. The provider may submit an appeal to DHCS in writing (30) calendar days after (60) calendar days from submission of the appeal to the MHP, if the MHP fails to respond.
5. Supporting documentation will include:
    a. Documentation supporting allegation regarding timeliness.
    b. Clinical records supporting the existence of medical necessity.
    c. A summary of the reason(s) why the MHP should have approved the MHP payment authorization.
6. DHCS will notify the MHP and the provider of its receipt of a request for appeal within seven (7) calendar days from the receipt of the request.
7. The MHP will submit requested documentation to DHCS within (21) calendar days of the date of the request.
8. DHCS will notify the provider and the MHP within (60) calendar days from the receipt of the MHP's documentation, in writing, of their decision or from the 21st calendar day after the request for documentation was received by the MHP.
9. If DHCS fails to act within the (60) calendar days, the appeal may be considered denied.
10. DHCS may permit an opportunity for the MHP and/or the provider to present oral arguments.
11. The provider may submit a revised request for the MHP payment authorization within (30) calendar days from receipt of the DHCS decision to uphold the appeal.
12. The MHP will have (14) calendar days from receipt of the provider's revised request to approve the MHP payment authorization.

PROVIDER APPEAL PROCESS-CLAIMS PROCESSING

1. A Fee-for-Service/MediCal hospital or psychiatric nursing facility may file an appeal concerning the processing or payment of its claims for payment for services directly to the fiscal intermediary.
    a. Appeal must be postmarked or faxed within (90) calendar days from the date the payment was due.
    b. The fiscal intermediary has (60) calendar days from the receipt of the appeal to make a determination in writing to the provider.
2. A MHP may file an appeal concerning the processing or payment of its claim for services paid through the Short/Doyle/Medi-Cal system to DHCS.
    a. Appeal must be postmarked or faxed within (90) calendar days of the date the payment was due.
    b. DHCS has (60) calendar days from the receipt of the appeal to make a determination in writing to the MHP.

PROVIDER APPEAL PROCESS- CLIENT RECORD REVIEW

INFORMAL APPEAL PROCESS

This process may only be used for disallowances of paid claims resulting from client record review findings.

1. The MHP, SUPT or Contracted Provider must submit the appeal request to DHCS in writing within (60) calendar days following the receipt of the client record review findings in dispute.
2. The appeal must include the following:
    a. Written documentation supporting the rationale for each disallowance in dispute.
    b. Other supporting information to be considered.
    c. Contact name, phone number and address.
    d. A statement requesting a decision is made solely on the written documentation submitted or with a telephone or face-to-face conference.
    e. Provide a copy of the request and accompanying documentation to the MHP, SUPT or Provider, if involved, at the same time filing the request with DHCS.
3. DHCS has (30) days to make a determination in writing.
4. The decision is considered final unless a formal appeal is requested by the entity initiating the informal appeal.

FORMAL APPEAL

Requests for a formal appeal may only be filed with the State Agency, specified in the written decision, after DHCS has issued a written decision regarding an informal appeal on the same matter and filed by the entity initiating the informal appeal.

1. The MHP, SUPT or Contract Provider must request the formal appeal within (30) calendar days of the issuance of the informal appeal decision.
2. A copy of the request is submitted to DHCS and to the MHP, SUPT or Contract Provider, if involved.

REFERENCES/ATTACHMENTS:

- Attachment A: MHSA Issue Resolution Process
- CCR Title 9, Chapter 11, §1850.205-210, 1850.305-325, 1850.350
- Federal HIPAA
- 42 CFR, Chapter IV, Subchapter C, Part 438, Subpart F, Part 438.420, Sec. 422.128
- 42 CFR Chapter IV, Part 438.10, Subpart A
- DHCS All Plan Letter (APL) 17-011

RELATED POLICIES:

- No. 01-01 Forms and Brochures Distribution
- No. 01-04 Second Opinions and Advocacy
- No. 02-01 Notices of Action

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Mental Health Treatment Center
X	Adult Contract Providers	X	Children Contract Providers

CONTACT INFORMATION:

- Quality Management Information
  QMInformation@SacCounty.net

Attachment A

Mental Health Services Act (MHSA) Issue Resolution Process

Sacramento County is committed to:

a. Addressing issues regarding MHSA in an expedient and appropriate manner;
b. Providing several avenues to file an issue;
c. Ensuring assistance is available, if needed, for the client/family member/provider/community member to file their issue; and
d. Honoring the Issue Filer's desire for anonymity.

Types of Issues to be resolved using this process:

a. Appropriate use of MHSA funds (Allegations of fraud, waste, and abuse of funds are excluded from this process. These types of allegations will be referred to the Sacramento County Compliance Office for investigation); and/or
b. Inconsistency between approved MHSA Plan and implementation; and/or
c. Sacramento County Community Program Planning Process.

Process:

An individual, or group of individuals, that is dissatisfied with any MHSA activity or process may file a issue at any point within the system. These avenues may include, but are not limited to, the County Mental Health Plan Director, County Compliance Officer, Patient Advocacy Program, Mental Health Providers, Mental Health Plan Problem Resolution, Mental Health Committees/Councils.

Issues will be forwarded to the Quality Management Program Manager, or specific designee of the Mental Health Director, either orally or in writing.

Upon receipt of the issue, the Quality Management Program Manager, or specific designee of the Mental Health Director, will determine if the issue is to be addressed through the MHSA Issue Resolution Process or if it is an issue of service to be addressed by the Mental Health Plan (MHP) Problem Resolution Process. If the issue is regarding service delivery to a consumer, the issue will be resolved through the MHP Problem Resolution Process.

If the issue is MHSA-related regarding the appropriate use of MHSA funding, inconsistency between the approved MHSA Plan and implementation, or Sacramento County community program planning process, the issue will be addressed as follows:

a. Issue Filer's concern(s) will be logged into a MHSA Issue Log to include the date of the report and description of the issue.
b. The Issue Filer will receive an acknowledgement of receipt of the issue, by phone or in writing, within the MHP Problem Resolution timeframes.
c. The Quality Management Program Manager, or specific designee of the Mental Health Director, shall notify the County's Mental Health Director and MHSA Program Manager of the issue received. Division of Behavioral Health Services (DBHS) staff will investigate the issue while maintaining anonymity of the Issue Filer.

d. The Quality Management Program Manager, or specific designee of the Mental Health Director, may convene an ad-hoc committee to review all aspects of the issue. This review process will follow the existing Problem Resolution timeframes.
e. The Quality Management Program Manager, or specific designee of the Mental Health Director, will communicate with the Issue Filer while the issue is being investigated and resolved.
f. Upon completion of the investigation, the Quality Management Program Manager, or specific designee of the Mental Health Director, shall issue a report to the Mental Health Director. The report shall include a description of the issue, brief explanation of the investigation, staff/ad-hoc committee recommendation(s) and the County resolution to the issue.
g. The Quality Management Program Manager, or specific designee of the Mental Health Director, shall notify the Issue Filer of the resolution, by phone or in writing and enter the issue resolution and date of the resolution into the MHSA Issue Log.
h. MHSA Issues and resolutions will be reported annually in the Quality Improvement Report.

If the Issue Filer does not agree with the local resolution, the Issue Filer may file an appeal with the following agencies: Mental Health Services Oversight and Accountability Commission (MHSOAC); California Mental Health Planning Council (CMHPC); or California Department of Health Care Services (DHCS).