SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD #AGI-001

Primary Category	Impacts
Line of Business	☒ Medi-Cal ☒ Non-Medi-Cal ☒Managed Care ☒Fee for Service ☒AMT ☒AOA ☒CJS ☒CYF ☒OSH ☒SUTS ☒TAY
Effected Parties	☒ All Workforce Members ☒ Practitioners ☒ BHSD ☒ Contracted Providers ☒ Inpatient Providers ☒Quality Managers

BHSD POLICY & PROCEDURE

I. BHSD P&P INFORMATION

Assigned Policy Name: Grievance Oversight Process

Assigned Policy Number: AGI-001

Policy Owner: Quality Management

Impacted Managed Care Policy Area(s): Mark All That Apply

☒	Administration (ADM)	☒	Appeals, Grievances, Incidents (AGI)
☒	Clinical (CLI)	☒	Compliance and Confidentiality (COP)
☐	Contracts (CON)	☐	Data Management (DTM)
☐	Fiscal (FIS)	☒	General Operations (GEO)
☒	Health and Safety (HAS)	☐	Health Education (HED)
☒	Legal (LEG)	☐	Medical & Pharmacy (MPS)
☒	Member Services & Materials (MSM)	☒	Personnel (PER)
☐	Provider Relations (PRR)	☒	Quality Management (QAM)
☐	Reporting (RPT)	☒	Service Delivery (SDM)
☐	Utilization Management (UMR)		

II. BHSD P&P APPROVAL

Section A: HHS Compliance and County Counsel

HHS Compliance: Date:

County Counsel: Date:

Section B: BHSD Director

BHSD Director: DocuSigned by: Sherri Terao DAB699BA2A1544D... Date: 6/13/2023

Approved/Issue Date: 5/23/2023	**Behavioral Health Services Director:**	Sherri Terao
Last Review/Revision Date:	**Next Review Date:** 5/22/2026	**Inactive Date:**

III. REPLACES	• BHSD PP #11400 Beneficiary Rights • BHSD PP #12000 Beneficiary Problem Resolution Process • BHSD PP #11000 Notice of Adverse Benefit Determination (NOABD) • BHSD PP#412-222 Client Problem Resolution Process • BHSD PP#412-310 Client Problem Resolution Process • BHSD PP #168 Notice of Action • BHSD PP #412-203 Notice of Action • DADS PP#425 System Feedback • DADS PP#500 Grievance Process Notice

IV. REFERENCES:

- 42 CFR §§ 431.211-214 Notice.
- 42 CFR § 438.208 Coordination and Continuity of Care
- 42 CFR § 431.220 When a Hearing Is Required.
- 42 CFR § 438.10 - Information requirements.
- 42 CFR § 438.228 Grievance and Appeals Systems.
- 42 CFR § 438.230 Sub contractual Relationships and Delegation.
- 42 CFR § 431.244(f) Expedited Appeals.
- 42 CFR § 438 Managed Care.
- 42 CFR § 438, Subpart F Grievance and Appeal System.
- 42 CFR § 438.10 Information Requirements.
- 42 CFR § 438.400 (b) Statutory Basis, Definitions, and Applicability.
- 42 CFR §§ 438.402 (b)-(c) General Requirements.
- 42 CFR §§ 438.404 (b)-(c) Timely and Adequate Notice of Adverse Benefit Determination.
- 42 CFR §§ 438.406 (a)-(b) Handling of Grievances and Appeals.
- 42 CFR §§ 438.408(a)-(f) Resolution and notification: Grievances and Appeals.
- 42 CFR § 438.410 (c) Expedited resolution of appeals.
- 42 CFR § 438.414 Information about the grievance and appeal system to providers and subcontractors.
- 42 CFR § 438.416 (b) Recordkeeping requirements.
- 42 CFR § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.
- 42 CFR § 438.424(a) Effectuation of reversed appeal resolutions.
- 45 CFR § 92.8 Notice requirement.
- 81 FR 27497 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, Chip Delivered in Managed Care, and Revisions Related to Third Party Liability.
- 81 FR § 31375 Nondiscrimination in Health Programs and Activities
- 9 CCR § 1810.200 Action.
- 9 CCR § 1850. 205.General Provisions.
- 9 CCR § 1850.210. Provision of Notice of Action.
- 9 CCR § 1850.215 Continuation of Services Pending Fair Hearing Decision.
- 9 CCR § 1810.216.2 Expedited Appeal.
- 9 CCR § 1810.216.4 Expedited Fair Hearing.
- 9 CCR § 1810.230.5 Notice of Action.
- 9 CCR §1810.415 Coordination of Physical and Mental Health Care
- 9 CCR §1820.100 Definitions.

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- 9 CCR §1830.100 General Provisions.
- 9 CCR §1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.
- 9 CCR §1830.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.
- 9 CCR §§1850.205-1850.215 Beneficiary Problem Resolution Processes.
- 22 CCR § 51014.1-2 Medical Assistance Pending Fair Hearing Decision.
- 22 CCR § 50179. Notice of Action Medi-Cal-Only Determinations or Redeterminations.
- 22 CCR § 53858 (e) Member Grievance Procedures.
- 28 CCR § 1300.67.04 Language Assistance Programs.
- 28 CCR §1300.68(a) Grievance System.
- GOV § 11135. Discrimination.
- HSC §1367.01 Health Care Service Plans.
- HSC §1368 Grievance System
- BHIN 18-010E. Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates
- BHIN 22-070. Parity Requirements for Drug Medi-Cal (DMC) State Plan Counties
- APL 21-004. Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
- APL 21-011. Grievance and Appeal Requirements, Notice and “Your Rights” Templates
- BHIN 22-036. MCPAR-for-MHP-and-DMC-ODS-Counties.
- DMC-ODS contract
- MHP Contract
- BHSD Policy #12000 Beneficiary Problem Resolution – NOABD’s
- BHSD Policy #11400 Beneficiary Rights
- BHSD Policy #10000 Coordination and Continuity of Care

V. PURPOSE:

To outline the Behavioral Health Services Department (BHSD) Plan Grievance Oversight Processes as they relate to Grievance Process Exemptions, Standard and Expedited Grievances.

VI. POLICY:

Behavioral Health Services Department (BHSD) maintains a Grievance process to ensure the receipt, review, and resolution of Grievances. The Plan is responsible for ensuring that our delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services (DHCS) guidance. These requirements are communicated to all County and Certified Contracted Providers.

The Plan delegates **Grievance Process Exemptions** activities to Participating Providers when a beneficiary or authorized representative contacts the Participating Provider by phone or in person with a Grievance that is resolved by the end of the next business day. If the Participating provider cannot resolve the grievance by the next business day, they must submit the grievance to The Plan's Quality Assurance unit before end of business on that second day. The Plan handles all **Standard and Expedited Grievances.**

VII. DEFINITIONS:

Behavioral Health Services Department (BHSD). Encompasses all behavioral health operations, managed care functions, contracts, interfaces, funding streams and services to Santa Clara County beneficiaries. Includes and is not limited to the local County Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), Mental Health Services Act (MHSA) and Santa Clara County programs reliant on General Funds.

Beneficiary. A person seeking or receiving behavioral health services from BHSD that is either a person certified as eligible for Medi-Cal or Medicare services, or someone for whom there is no third-party payor who may become responsible for paying all or part of the person's medically necessary behavioral health services.

County Contracted Providers (CCP). County Contracted Providers (CCPs) that agree to provide covered specialty mental health services and/or substance use treatment services to Beneficiaries, or any other organization or person who agrees to perform any administrative function or service for BHSD specifically related to securing or fulfilling its obligations to the DHCS under the terms of their existing contracts.

Discrimination Grievance. Any Beneficiary grievance alleging discrimination on the basis of any characteristic protected by federal or state nondiscrimination law. This includes, without limitation, sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. This requirement includes language access complaints and complaints alleging failure to make reasonable accommodations under the ADA.

Expedited Request. An Expedited Request occurs when the standard process could jeopardize the Beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. If the Beneficiary or Provider expedited hearing request is approved, a decision will be issued within three (3) working days of the date of the request. Expedited Requests may include Grievances, Appeals and State Fair Hearings. Expedited Requests must be resolved within seventy-two (72) hours of receipt of the request.

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Grievance. An expression of dissatisfaction about any part of services provided, with the exception of an adverse benefit determination (NOABD), which warrant an appeal. Grievances may include, but are not limited to access to services, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Beneficiary's rights regardless of whether remedial action is requested. Grievances can also include 42 CFR Violations and discrimination grievances. Grievance includes a Beneficiary's right to dispute an extension of time proposed by BHSD to make an authorization decision. There is no distinction between an informal and formal Grievance.

Grievance Process Exemption. Grievances received over the telephone or in-person by the Plan, or a network provider of the Plan, that are resolved to the Beneficiary's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written Acknowledgement and disposition letter.

Representative. A person who is authorized by the Beneficiary to act on behalf of or assisting a Beneficiary, and may include, but is not limited to, a family member, a friend, or a person legally identified as having the Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Resolution. The Grievance has reached a final disposition with respect to the Beneficiary's submitted Grievance. BHSD Providers will send the Notification of Grievance Resolution (NGR) to notify Beneficiaries of the results of the Grievance Resolution. The NGR shall contain a clear and concise explanation of the BHSD Provider or Plan's decision.

The Plan. Provides oversight to behavioral health Medi-Cal carve out programs. BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).

VIII. OVERSIGHT AND MONITORING PROCEDURE

Processes	Requirements
Grievance System Oversight Process	1. The Plan has established, implemented, and maintains a Grievance System to ensure receipt, review, and resolution of Grievances according to current grievance policy and procedure requirements. The exception, as also noted below, is that Standard Grievances are normally to be resolved within ninety (90) days. a. Requires annual training on the Plan's Grievance system

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	to ensure Participating Providers are appropriately handling Grievances. b. Notifies Beneficiaries about its Grievance process through Beneficiary Handbook, posted notices at the clinics, as part of the intake packet. Information on the county grievance process is posted on the county website, and other applicable publicly facing platforms. c. Maintains a toll-free number telephone number available 24/7 a Beneficiary can contact for Grievances **(800) 704-0900** d. Provides self-addressed stamped Grievance materials at all sites: **Quality Management** P.O. Box 28504 San Jose, CA 95159-9903 2. Grievances are managed by the Quality Assurance – Utilization Management team. a. The Quality Assurance Team meets weekly to discuss and process grievances to ensure staff consistency and compliance with applicable state and federal laws and regulations. b. Quality Insurance Coordinator's (QIC) or designated staff will use the required state templates to communicate with the Beneficiary to ensure: i. Notification of the limited time available for Grievances and Appeals sufficiently enough in advance of Resolution timeframe. ii. Receipt of materials about Beneficiary rights in the Grievance and Appeal process. iii. Language assistance, if needed. iv. Informed of the limited time available to present evidence and testimony, in person and writing, and make legal and factual arguments for an Expedited Appeal sufficiently in advance of the Resolution timeframe for the Expedited Appeal. v. Steps they can take if they disagree with a decision. vi. Timeline requirements. Standard Grievances are normally to be resolved within ninety (90) days. vii. Continuation of services can be requested (Aid Paid Pending).

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	3. A Grievance Review Committee meets monthly to identify system gaps and patterns that are problematic to develop corrective action for system improvement. 4. The Plan ensures linguistic and cultural needs of the population are met, including those needs of Beneficiaries with disabilities such as visual or communicative impartments. Plan assistance includes but is not limited to: a. Translation of Grievance and Appeal procedures, forms and plan responses to Grievances and Appeals. b. Access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate. c. Maintains current policies and processes to meet non-discrimination auxiliary and language assistance services readability requirements.
Discrimination Grievance Coordination	1. The Plan adopts Discrimination Grievance procedures that ensure prompt and equitable resolution of discrimination-related complaints. A beneficiary or representative may file a discrimination grievance at any level. a. BHSD i. Grievance & Appeal - Behavioral Health Services - County of Santa Clara (sccgov.org) b. DHCS Office of Civil Rights i. discrimination-grievance-procedures (ca.gov) c. U.S. Health and Human Services Office for Civil Rights i. Filing with OCR | HHS.gov
Discrimination Grievances Reporting Requirements	1. Within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the Plan shall submit detailed information regarding the grievance to DHCS Office of Civil Rights' designated Discrimination Grievance email box. The County shall submit the following detailed information via secured email to: DHCS.DiscriminationGrievances@dhcs.ca.gov. a. The original complaint. b. The provider's or other accused party's response to the grievance. c. The County's personnel contact information responsible

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	for the County's investigation and response to the grievance. d. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance. e. All correspondence(s) with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary; 1. The original complaint; 2. The provider's or other accused party's response to the grievance; 3. The County's personnel contact information responsible for the County's investigation and response to the grievance; 4. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance; 5. All correspondence(s) with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary; and Behavioral Health Information Notice No.: 22-070 Page 4 December 30, 2022 6. The results of the County's investigation, including, but not limited to, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination. f. The results of the County's investigation, including, but not limited to, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

IX. WORKFLOW PROCEDURE	
Responsible Party	**Action Required**
Participating Providers	1. Maintain Grievance Plan Problem Resolution Process materials in all County of Santa Clara Threshold and Concentration Standard Languages and make specific forms available in large type font. Materials, forms, and self-addressed envelopes must be readily available for the Beneficiary to obtain without having to ask for them. 2. Must participate in annual training on Plan, state and federal Grievance Resolution Process requirements, timelines, and reporting.

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	3. Provide any reasonable assistance to Beneficiary in completing the forms and other procedural steps related to a Grievance. This includes but is not limited to providing interpreter services and toll-free numbers with TTY and interpreter capability. 4. Handle Grievance Process Exemptions that can be resolved by the end of the next business day. 5. Document Grievance Process Exemptions in the Problem Resolution Log. 6. Grievance process exemptions not resolved within 24 hours of receipt of that grievance require notification to Quality Management. 7. Submit Log of Grievance Process Exemptions to BHSD Quality Assurance on the **5th day of each month** for prior month. a. Ensure Beneficiary Grievance Logs are accurate and complete prior to 5th of the month submissions. 8. Securely store problem Resolution documentation in a confidential secure manner, outside of the Beneficiary record, for up to **ten (10) years after the Resolution**.
Quality Assurance Manager	1. At the Beneficiary's request, identify staff or another individual to be responsible for assisting a Beneficiary with the Grievance. 2. Assign a Quality Improvement Coordinator to handle the Grievance, Appeal or NOABD. 3. Provide quality management oversight processes to review Grievances monthly to confirm: a. Ensure staff who make decisions on Grievances and Appeals have not been involved in any previous level of review or decision-making. b. Identify an individual who has the authority to require corrective action and that the decision-maker was not a subordinate of any individual who was involved in a previous level of review. c. The decision-maker will be a health care professional with clinical expertise in treating a Beneficiary's condition or disease if any of the following apply: i. Any Grievance involving clinical issues. d. The information was provided free of charge and sufficiently in advance of the Resolution timeframe. e. The participating provider and/or decision-maker did not discriminate against a Beneficiary because the Beneficiary filed a Grievance or an Appeal.

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	f. Beneficiary Grievance Logs are accurate and complete prior to 5th of the month submissions. g. Provide the details and dates related to contact(s) with the beneficiary and/or their stakeholders upon request. h. Securely store Beneficiary problem Resolution documentation in a confidential secure manner, outside of the Beneficiary record, for up to **ten (10) years after the Resolution**.
Assigned Plan Quality Improvement Coordinator or Designee(s)	1. Conducts activities identified in this policy. 2. Includes name and personal contact information in the Acknowledgement Letter or Grievance Resolution NOABD. 3. Review Grievances prior to the disposition phase if a Resolution is not reached to the satisfaction of the Beneficiary. 4. Reviews and presents de-identified Grievances to BHQIC each quarter to identify system gaps and patterns that are problematic in order to develop corrective action for system improvement. 5. Categorize Grievances by issue which include but depending upon further updates from DHCS may not be limited to: a) Related to Customer Service b) Related to Case Management c) Access to Care d) Quality of Care e) County (Plan) communication f) Payment/Billing issues g) Suspected Fraud h) Abuse, Neglect or Exploitation i) Lack of timely response j) Denial of Expedited Appeal k) Filed for other reasons. 6. Takes appropriate action to remedy any problems identified. 7. Prepares the report to for Plan's Quality Improvement Committee, the Plan's administration, or another appropriate body within the Plan's operations. 8. Ensures Grievance Process Exemptions are included in its Beneficiary Grievance and Appeal Report that is submitted to DHCS. 9. Complete and submit materials per Submission Standards Timeline

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Discrimination Grievance Coordinator	1. Responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. 2. Will be available to: a. Answer questions and provide appropriate assistance to the county's staff, providers, and beneficiaries regarding the state and federal nondiscrimination legal obligations. b. Advise the County about nondiscrimination best practices and accommodating persons with disabilities. c. Investigate and process any Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, and/or GOV § 11135 grievances received by the County.
Grievance Review Committee	1. A group of leadership, division directors and other representatives that review grievance process exemptions, grievances, and discrimination grievances monthly as a means to identify system gaps and patterns that are problematic to develop corrective action for system improvement.
Provider Relations	1. For new sites and re-certifications, reviews provider policies and procedures identified on the DHCS Protocol for compliance with federal and state regulatory requirements. 2. During site visits, and via photograph when unable to be onsite, checks to make certain Participating Providers have all the Grievance materials posted in all Threshold and Concentration Standard Languages and that Grievance materials are available to Beneficiaries without having to make a request. 3. Will issue a Corrective Action Plan if the Participating Provider is out of compliance.
Attachments	A. Monthly Participating Provider Grievance Process Exemption Report

X. REVISION HISTORY

Policy Name	Active Dates Range	Date Approved	Reason for Review	Summary of Changes