Mental Health Services Division
Annual Medi-Cal Beneficiary Grievance and Appeal Report
Fiscal Year: 2016-2017
FRESNO COUNTY MHP

CATEGORY	PROCESS			DISPOSITION		
	GRIEVANCE	APPEAL	EXPEDITED APPEAL	COMPLETED	REFERRED OUT	PENDING as of June 30
ACTIONS (Appeals on Actions)						
NOTICE OF ACTION - A						
NOTICE OF ACTION - B						
NOTICE OF ACTION - C						
NOTICE OF ACTION - D						
NOTICE OF ACTION - E						
ALL OTHER ACTIONS						
TOTAL	**N/A**	**0**	**0**	**0**	**0**	**0**
ACCESS						
SERVICE NOT AVAILABLE	2			2		
SERVICE NOT ACCESSIBLE						
TIMELINESS OF SERVICES						
24/7 TOLL-FREE ACCESS LINE						
LINGUISTIC SERVICES						
OTHER ACCESS ISSUES						
TOTAL	**2**	**N/A**	**N/A**	**2**	**0**	**0**
QUALITY OF CARE						
STAFF BEHAVIOR CONCERNS	24			24		
TREATMENT ISSUES OR CONCERNS	12			11		1
MEDICATION CONCERN	4			4		
CULTURAL APPROPRIATENESS						
OTHER QUALITY OF CARE ISSUES						
TOTAL	**40**	**N/A**	**N/A**	**39**	**0**	**1**
CHANGE OF PROVIDER	**22**	**N/A**	**N/A**	**21**		**1**
CONFIDENTIALITY CONCERN	**1**	**N/A**	**N/A**	**0**		**1**
OTHER						
FINANCIAL	1			1		
LOST PROPERTY	1			1		
OPERATIONAL	2			2		
PATIENTS' RIGHTS						
PEER BEHAVIORS	1			1		
PHYSICAL ENVIRONMENT						
OTHER GRIEVANCE NOT LISTED ABOVE	4			4		
TOTAL	**9**	**N/A**	**N/A**	**9**	**0**	**0**
GRAND TOTALS	**74**	**0**	**0**	**71**	**0**	**3**

GRIEVANCE DEFINITION (Title 9, Section 1810.218.1)
"Grievance" means a beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an appeal as defined in Section 1810.203.5 filed through the MHPs grievance process as described in Sections 1850.205 and 1850.206 or a provider's grievance process if the MHP has delegated the process to a provider in accordance with Section 1850.209.

GRIEVANCE PROCESS DEFINITION (Title 9, Section 1850.206)
In addition to meeting the requirements of Section 1850.205 (Beneficiary Problem Resolution Processes/General Provisions) the grievance process shall, at a minimum: (a) Allow beneficiaries to present their grievance orally or in writing. (b) Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension or if the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a NOA as defined in Section 1810.230.5. (c) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

APPEAL DEFINITION (Title 9, Section 1810.203.5)
"Appeal" means: (a) A request by a beneficiary or a beneficiary's representative for review of an action as defined in Section 1810.200. (b) A request by a beneficiary or a beneficiary's representative for review of a provider's determination to deny or modify a beneficiary's request for a covered Specialty Mental Health Service (SMHS). (c) A request by a beneficiary or a beneficiary's representative for review of the timeliness of the delivery of a SMHS when the beneficiary believes that services are not being delivered in time to meet the beneficiary's needs, whether or not the mental health plan has established a timeliness standard for the delivery of the service. (d) A request by an MHP and/or MHP subcontractor for review of client record review findings that resulted in the disallowance of paid claims.

APPEAL PROCESS DEFINITION (Title 9, Section 1850.207)
In addition to meeting the requirements of Section 1850.205 (Beneficiary Problem Resolution Processes/General Provisions) the appeal process shall, at a minimum: (a) Allow a beneficiary to file an appeal orally or in writing. (b) Require a beneficiary to follow an oral appeal with a written appeal. The date the MHP receives the oral appeal must be considered the filing date for the purpose of applying the appeal timeframes in Subsection (c). (c) Provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an extension or the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a NOA as defined in Section 1810.230.5. (d) Inform the beneficiary of his or her right to request a fair hearing after the appeal process of the MHP has been exhausted. (e) Allow the beneficiary to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing. (f) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process. (g) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal. (h) Notify the beneficiary and/or his or her representative of the resolution of the appeal in writing. The notice must contain: (1) The results of the appeal resolution process. (2) The date that the appeal decision was made. (3) If the appeal is not resolved wholly in favor of the beneficiary, the notice must also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal. (i) Promptly provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services.

EXPEDITED APPEAL DEFINITION (Title 9, Section 1810.216.2)
"Expedited Appeal" means an appeal as defined in Section 1810.203.5 to be used when the MHP determines, or the beneficiary and/or the beneficiary's provider certifies, that following the timeframe for an appeal as established in Section 1850.207 would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.
EXPEDITED APPEAL PROCESS DEFINITION (Title 9, Section 1850.208)
In addition to meeting the requirements of Section 1850.205 (Beneficiary Problem Resolution Processes/General Provisions), the appeal process shall, at a minimum: (a) Be used when the MHP determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. (b) Allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal. (c) Ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal. (d) Resolve an expedited appeal and notify the affected parties in writing, no later than three working days after the MHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the MHP determines that there is need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a NOA as defined in Section 1810.230.5. (e) Provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. The written notice shall meet the requirements of Section 1850.207(h). (f) If the MHP denies a request for expedited appeal resolution, the MHP shall: (1) Transfer the expedited appeal request to the timeframe for appeal resolution as required by Section 1850.207(c). (2) Make reasonable efforts to give the beneficiary and/or his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a NOA as defined in Section 1810.230.5.

DISPOSITION DEFINITIONS
Completed (Resolved) - The MHP has notified the beneficiary within the regulatory timeframe on the Grievance/Appeal/Expedited Appeal resolution. The resolution includes both issues that have been resolved to beneficiary satisfaction or not. Resolution also includes beneficiaries who have withdrawn the Grievance/Appeal/Expedited Appeal, moved, are deceased, or are unresponsive to all the MHP's efforts to contact them. **Referred** - The Grievance/Appeal/Expedited Appeal was referred to the appropriate agency or department outside the MHP as the grievance was not within MHP's jurisdiction to resolve. **Pending** -The Grievance/Appeal/Expedited Appeal was awaiting disposition after the June 30 reporting period.
ACTION DEFINITIONS (Title 9, Sections 1810.200, 1810.230.5 and 1850.210)
Only Include Actions that result in an appeal or expedited appeal. An **ACTION** requiring a NOA (A-E) occurs as the result of the following: a. Denial, modification, reduction, or termination of a provider's request for MHP payment authorization of a SMHS covered by the MHP. b. A determination by the MHP or its providers that the medical necessity criteria has not been met and the beneficiary is not entitled to any SMHS. c. A failure by the MHP to provide SMHS covered by the MHP within the timeframe for delivery of the service established by the MHP; or d. A failure by the MHP to act within the timeframes for resolution of grievances, appeals, or expedited appeals. In accordance with Title 9, Section 1810.200
NOA A - (Assessment) Is used when the MHP, or its providers, assess a Medi-Cal beneficiary and decides the beneficiary's mental health condition does not meet medical necessity criteria to receive SMHS, and therefore no SMHS will be provided. The NOA-A form also includes information regarding appeals and expedited appeals. In accordance with Title 9, Section 1850.210
NOA B - Is used when the MHP denies or modifies an MHP payment authorization request by a provider for SMHS, or denies or modifies a previously authorized service. The action is based on the determination that the beneficiary's mental health condition does not meet medical necessity criteria to receive requested service, that the service requested is not covered, or that the MHP did not receive requested additional information from the beneficiary's provider within required timeframes to approve payment of proposed service. The NOA-B form also includes information regarding appeals and expedited appeals. In accordance with Title 9, Section 1850.210 (a) and (c)

NOA C - (Post-Service Denial) Is used when the MHP denies or modifies a payment authorization request from a provider for SMHS that has already been provided. The action is based on the determination that the beneficiary's mental health condition does not meet medical necessity criteria to receive requested service, that the service requested is not covered, or that the MHP did not receive requested additional information from the beneficiary's provider within required timeframes to approve payment of the service. The NOA-C may include a statement that reads "this is not a bill" so that beneficiaries will know that they are not responsible for the cost of the services. The NOA-C form also includes information regarding appeals and expedited appeals. In accordance with Title 9, Section 1850.210 (b) and (c)
NOA D - Is used if the MHP fails to notify the affected parties of a grievance decision within 60 calendar days, an appeal decision within 45 days, or an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to Sections 1850.206, 1850.207 or 1850.208 respectively, the MHP must provide a beneficiary of the MHP with a NOA if the MHP fails to notify the affected parties of the grievance, appeal or expedited appeal decision within the extension period. In accordance with Title 9, Section 1850.210 (d)
NOA E - Is used if the MHP fails to provide a SMHS covered by the MHP within the timeframe for delivery of the service established by the MHP. In accordance with Title 9, Section 1850.210 (e)
ALL OTHER ACTIONS - A beneficiary may file an appeal or expedited appeal whether or not a NOA has been issued. In accordance with DMH LETTER NO.: 05-03
ACCESS DEFINITION
Each MHP must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services. In accordance with 1915(b) Medi-Cal Specialty Mental Health Services Waiver, Page 42 Also refer to CFR 438.206

QUALITY OF CARE DEFINITION
The degree to which mental health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Services provided should be consistent with the following values: **Safe** – avoiding injuries to beneficiaries from the care that is supposed to help them. **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse). **Patient-Centered** – providing care that is respectful of and responsive to individual beneficiary's preferences, needs, and values and ensuring that patient values guide all clinical decisions. **Efficient** – avoiding waste, in particular waste of equipment, supplies, ideas, and energy. **Equitable** – providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status. In Accordance with the Institute of Medicine, aka National Academy of Medicine – Internet source
CHANGE OF PROVIDER DEFINITION
Only include grievances filed concerning Change of Provider requests, not the Change of Provider request itself. The beneficiary files a grievance concerning a requests to change persons providing the SMHS. Annual Review Protocol for Consolidated SMHSs and Other Funded Services, Section A: Access, Question #4
CONFIDENTIALITY DEFINITION
A beneficiary reports that their privacy has been violated by a staff or a peer.
OTHER CATEGORY DEFINITIONS
Financial - Any issues concerning money either personal finances or cost of treatment **Lost Property** - Lost or stolen items while in treatment. **Operational** - Issue with how the program is being managed. **Patient's Rights** - Rights are violated by peer or staff members. **Peer Behaviors** - Conflicts with peers. **Physical Environment** - Issues having to do with treatment buildings and environment.