GRIEVANCES

Authority & Quality Improvement Services

EFFECTIVE SEPTEMBER 17TH, 2018

- Per MHSUDS Information Notice NO.: 18-010E
  - Mental Health and Substance Use Disorder Services Information Notice (IN) is to provide Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot counties, herein referred to as Plans unless otherwise specified, with clarification and guidance regarding the application of revised federal regulations for processing grievances and appeals.

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule,[1] aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. MHPs and DMC-ODS pilot counties are classified as Prepaid Inpatient Health Plans, and therefore, must comply with all applicable federal managed care requirements The Final Rule stipulates new requirements for the handling of grievances and appeals that became effective July 1, 2017.[2]

This IN also includes policy changes the Department of Health Care Services (DHCS) has made to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule). On March 30, 2016, CMS issued the Parity Rule in the Federal Register (81.Fed.Reg. 18390) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. As such, this IN largely mirrors the requirements outlined in All Plan Letter 17-006 for managed care plans.

REVISED REQUIREMENTS

I. GRIEVANCES

The federal regulations[3] redefined the term "grievance" to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The definition specifies that grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the Plan to make an authorization decision.[4] There is no distinction between an informal and formal grievance.

A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination" (see below).

The Plan shall not discourage the filing of grievances. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and,

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[1] 81 FR 27497
[2] Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F
[3] Title 42, CFR, Section 438.400(b)
[4] Title 42, CFR, Section 438.400(b)

therefore, a grievance. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievance will be analyzed to monitor trends.

A. Timeframes for Filing

In accordance with 42 CFR §438.402, a beneficiary may file a grievance at any time.

B. Method of Filing

A beneficiary, or a provider and/or authorized representative, may file a grievance either orally or in writing.

C. Standard Grievances

1. Acknowledgment

The Plan shall provide to the beneficiary written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the beneficiary may contact about the grievance. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance.

2. Resolution

Each Plan must resolve grievances within the established timeframes. For standard resolution of a grievance and notice to affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the Plan receives the grievance. [5] Plans must comply with the following requirements for resolution of grievances:

a. "Resolved" means that the Plan has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
b. Plans shall comply with the established timeframe of 90 calendar days for resolution of grievances, except as noted below.
c. The timeframe for resolving grievances related to disputes of a Plan's decision to extend the timeframe for making an authorization decision shall no exceed 30 calendar days.[6]
d. The Plan shall use the enclosed written NGR to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.

[5] Title 42, CFR, Section 438.408(b)
[6] Title 28, California Code of Regulations (CCR), Section 1300.68(a)

e. Federal regulations[7] allow the Plan to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the Plan shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary's interest. In the event that resolution of a standard grievance is not reached within 90 calendar days as required, the Plan shall provide the beneficiary with the applicable NOABD, and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.

   If the Plan extends the timeframe, not at the request of the beneficiary, it must complete all of the following: (a) give the beneficiary prompt oral notice of the delay, (b) within two calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision, and (c) resolve the grievance no later than the date the extension expires.

D. Grievance Process Exemptions

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 acknowledgment and disposition letter.

Grievances received via mail by the Plan, or a network provider of the Plan, are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a Plan or a network provider of the Plan receives a complaint pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

Plans shall maintain a log of all grievances containing the date of receipt of the grievance, the name of the beneficiary, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance. Plans must transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the Plan's Quality Improvement Committee, the Plan's administration or another appropriate body within the Plan's operations. The Plan shall ensure exempt grievances are included in its Beneficiary Grievance and Appeal Report that is submitted to DHCS.

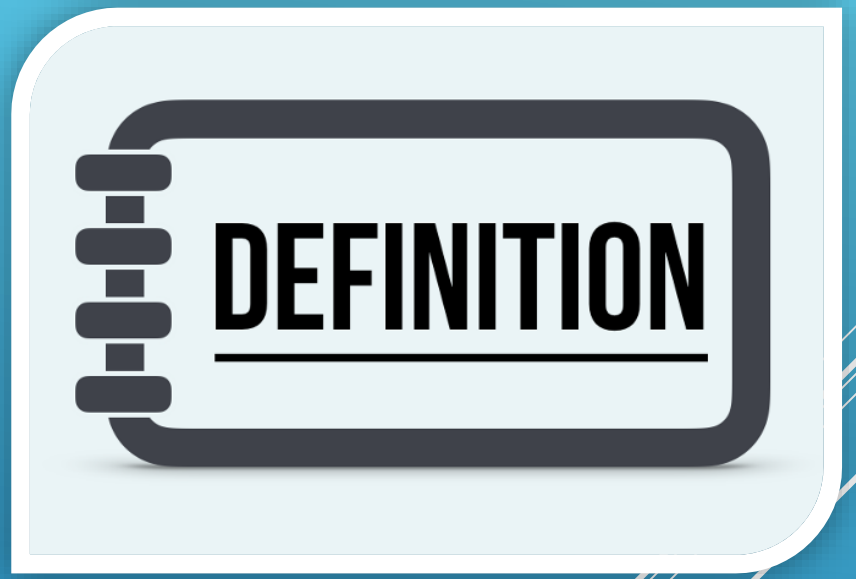
[7] Title 42, CFR, Sections 438.408(b) and (c)

WHO DOES THIS PERTAIN TO?

- AOABH
- CYPBH
- DMC-ODS
- Medi-Cal Beneficiary
  - Refer to the Formal Grievance Workflow
- Non Medi-Cal Beneficiary
  - Refer to the Informal Grievance Workflow

DEFINITION

- **Beneficiary**: "Beneficiary" includes a parent/guardian of a minor, conservator, or other authorized representative
  - For DMC-ODS, an underage minor is still the identified Beneficiary
  - Medi-Cal Beneficiary is a person with Medi-Cal Coverage
  - Non Medi-Cal Beneficiary is a person without Medi-Cal Coverage and/or without insurance
- **Informal Grievance Workflow**: The process taken for Non Medi-Cal Beneficiaries
- **Formal Grievance Workflow**: The process taken for Medi-Cal Beneficiaries
- **Days**: Defined as business days
- **Investigating Representative**: An AQIS clinical staff designated to investigate grievance
- **Grievance Representative**: An AQIS staff designated to receive and assign initial grievance
- **Rendering Provider:** A Plan Coordinator(PC), Personal Service Coordinator(PSC), Counselor, Intake Coordinator (IC), etc.



WHAT IS A GRIEVANCE?

- A beneficiary's expressed dissatisfaction to the MHP, DMC-ODS, or any provider about any matter having to do with the provision of Medi-Cal services
- The expressed dissatisfaction is defined as a grievance, whether or not it is submitted in writing, whether or not the beneficiary states that they wish to file a grievance, even if the beneficiary explicitly states they do not want to file a grievance and whether or not the beneficiary uses the term "grievance"

WHAT GRIEVANCES MAY INCLUDE (BUT ARE NOT LIMITED TO)

- Quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the beneficiary's rights regardless of whether beneficiary requested a grievance process
  - MHP Handbook: http://www.ochealthinfo.com/bhs/about/medi_cal
  - DMC-ODS Handbook: http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods
- Beneficiary's right to dispute an extension of time proposed by the Plan to make an authorization decision

COMPLAINT = GRIEVANCE

- A complaint is the same as a formal grievance
- A complaint shall be considered a grievance unless it meets the definition of an Adverse Benefit Determination" (e.g. a denial or reduction of services)
- A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance
- Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance

HOW TO IDENTIFY A COMPLAINT/GRIEVANCE

- Soliciting feedback is **NOT** a grievance
- Comment: "It's hot in this office."
- Suggestion: "It's hot in this office. I think you should turn on the air."
- Complaint/Grievance: "It's hot in this office which is making me feel anxious, and you aren't helping me feel better."

EXCEPTION TO A COMPLAINT/GRIEVANCE

- DO NOT complete a grievance while providing a crisis service

HOW TO IDENTIFY A COMPLAINT/GRIEVANCE FOR A CHANGE OF PROVIDER

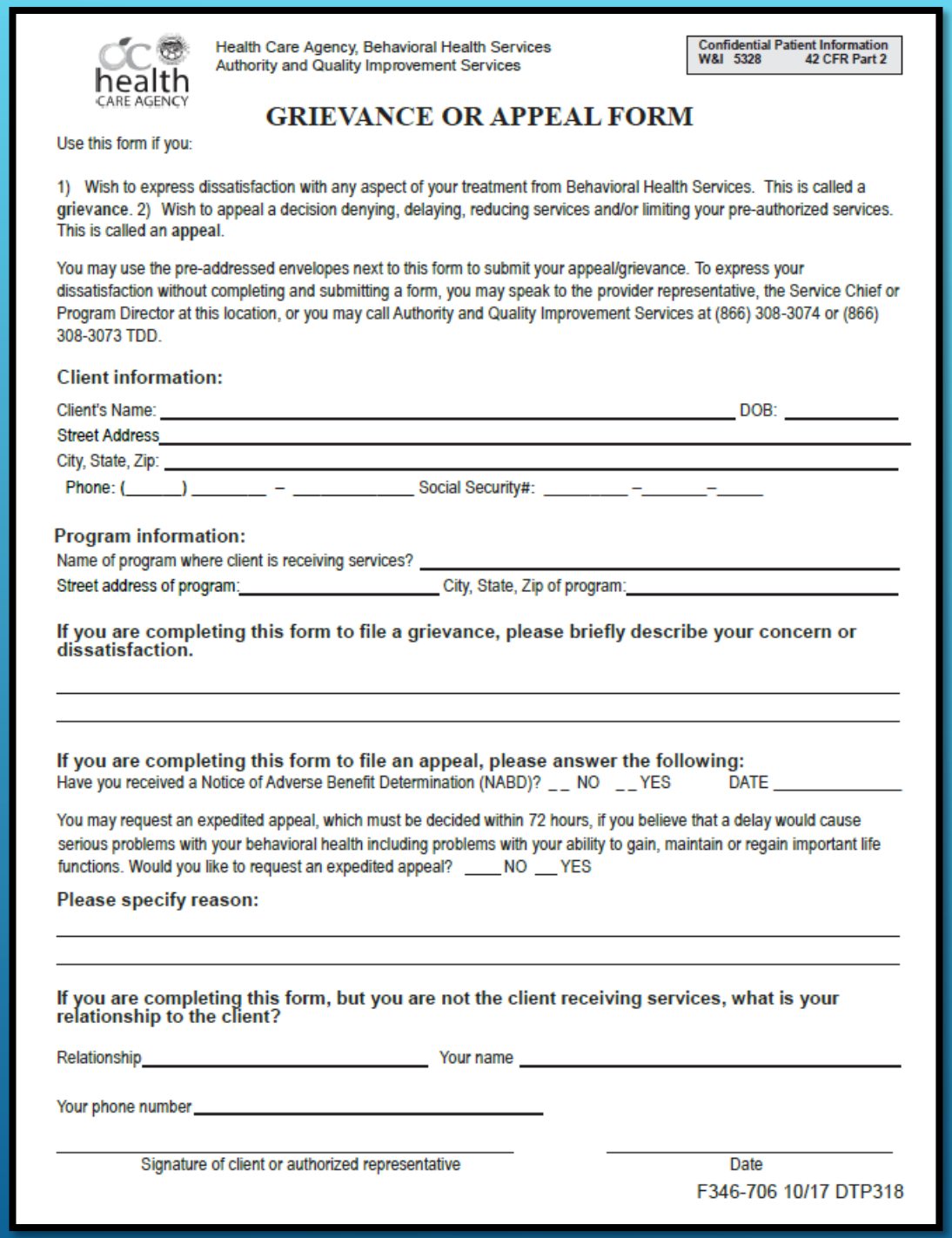
- Request for a change of provider
- Depending on the statement, determine grievance

INFORMAL GRIEVANCE WORKFLOW

- Non Medi-Cal Beneficiary ONLY
- Gather information regarding complaint/grievance
- Attempt to resolve
  - If not resolved, complete the Grievance or Appeal Form

- This is the only required form for a complaint/grievance made by a Non Medi-Cal Beneficiary

- Complete all fields
- Ensure name, address and phone number are correct



Health Care Agency, Behavioral Health Services
Authority and Quality Improvement Services

Confidential Patient Information
W&I 5328 42 CFR Part 2

GRIEVANCE OR APPEAL FORM

Use this form if you:

1) Wish to express dissatisfaction with any aspect of your treatment from Behavioral Health Services. This is called a **grievance**. 2) Wish to appeal a decision denying, delaying, reducing services and/or limiting your pre-authorized services. This is called an **appeal**.

You may use the pre-addressed envelopes next to this form to submit your appeal/grievance. To express your dissatisfaction without completing and submitting a form, you may speak to the provider representative, the Service Chief or Program Director at this location, or you may call Authority and Quality Improvement Services at (866) 308-3074 or (866) 308-3073 TDD.

Client information:

Client's Name: _____ DOB: _____
Street Address _____
City, State, Zip: _____
Phone: (_____) _____ – _____ Social Security#: _____–_____–_____

Program information:

Name of program where client is receiving services? _____
Street address of program: _____ City, State, Zip of program: _____

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

_____
_____

If you are completing this form to file an appeal, please answer the following:

Have you received a Notice of Adverse Benefit Determination (NABD)? __ NO __ YES DATE _____

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? ____NO __ YES

Please specify reason:

_____
_____

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

Relationship _____ Your name _____

Your phone number _____

_____ _____
Signature of client or authorized representative Date

F346-706 10/17 DTP318

FORMAL GRIEVANCE WORKFLOW

- Medi-Cal Beneficiary ONLY
- External workflow
  - Clinics/Contract Clinics
- Internal workflow
  - AOABH/CYPBH/DMC-ODS AQIS

EXTERNAL WORKFLOW: FRONT OFFICE STAFF

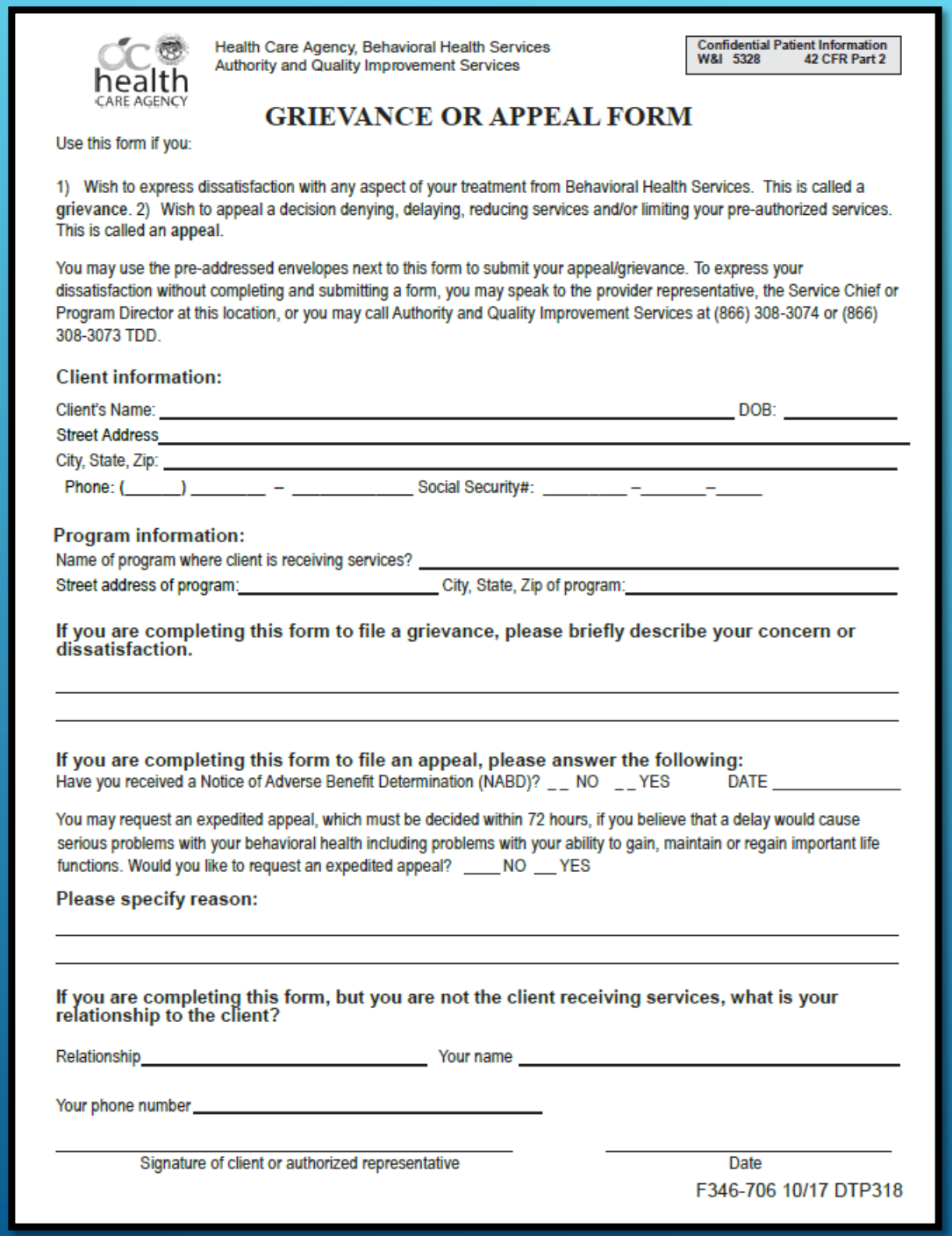
- Receive complaint/grievance
- Inform assigned Rendering Provider (e.g. PC/PSC/Counselor)
- If Rendering Provider is unavailable, inform back up Rendering Provider (e.g. IC/OD)
- If the back up Rendering Provider is unavailable, inform Provider Representative
- If the Provider Representative is unavailable, inform a Supervisor (e.g. Service Chief, Program Director)

EXTERNAL WORKFLOW: CLINICAL STAFF

- Receive grievance
- Verify Medi-Cal status
  - If no, attempt to resolve with Informal Grievance Workflow
  - If yes, attempt to resolve concern with the client and continue with Formal Grievance Process

EXTERNAL WORKFLOW: CLINICAL STAFF

- By end of next business day, complete and send the Grievance or Appeal form along with the Grievance Tracking Form
- Four ways to Send Grievance Forms
  - Contact AQIS Grievance Line 866-308-3074 TTD 866-308-3073 by phone and provide all required information on the form.
  - Hand write Grievance or Appeal form and Grievance Tracking Form, scan and secure/encrypt email to AQISGrievance@ochca.com or fax to AQIS at (714)834-6575.
  - Complete electronic version of Grievance or Appeal Form and Grievance Tracking Form and secure/encrypt email to AQISGrievance@ochca.com or fax to AQIS at (714) 834-6575
  - For 24/7 Mobile Crisis Team, complete, secure, and send templated email to AQISGrievance@ochca.com or fax to AQIS at (714) 834-6575 (other than crisis service as noted earlier)



Health Care Agency, Behavioral Health Services
Authority and Quality Improvement Services

Confidential Patient Information
W&I 5328 42 CFR Part 2

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Client information:

Client's Name: _____ DOB: _____
Street Address _____
City, State, Zip: _____
Phone: (_____) _____ – _____ Social Security#: _____ –_____–____

Program information:

Name of program where client is receiving services? _____
Street address of program:_____ City, State, Zip of program:_____

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

_____
_____

If you are completing this form to file an appeal, please answer the following:
Have you received a Notice of Adverse Benefit Determination (NABD)? __ NO __ YES DATE _____

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? ____NO ___YES

Please specify reason:

_____
_____

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

Relationship_____ Your name _____

Your phone number_____

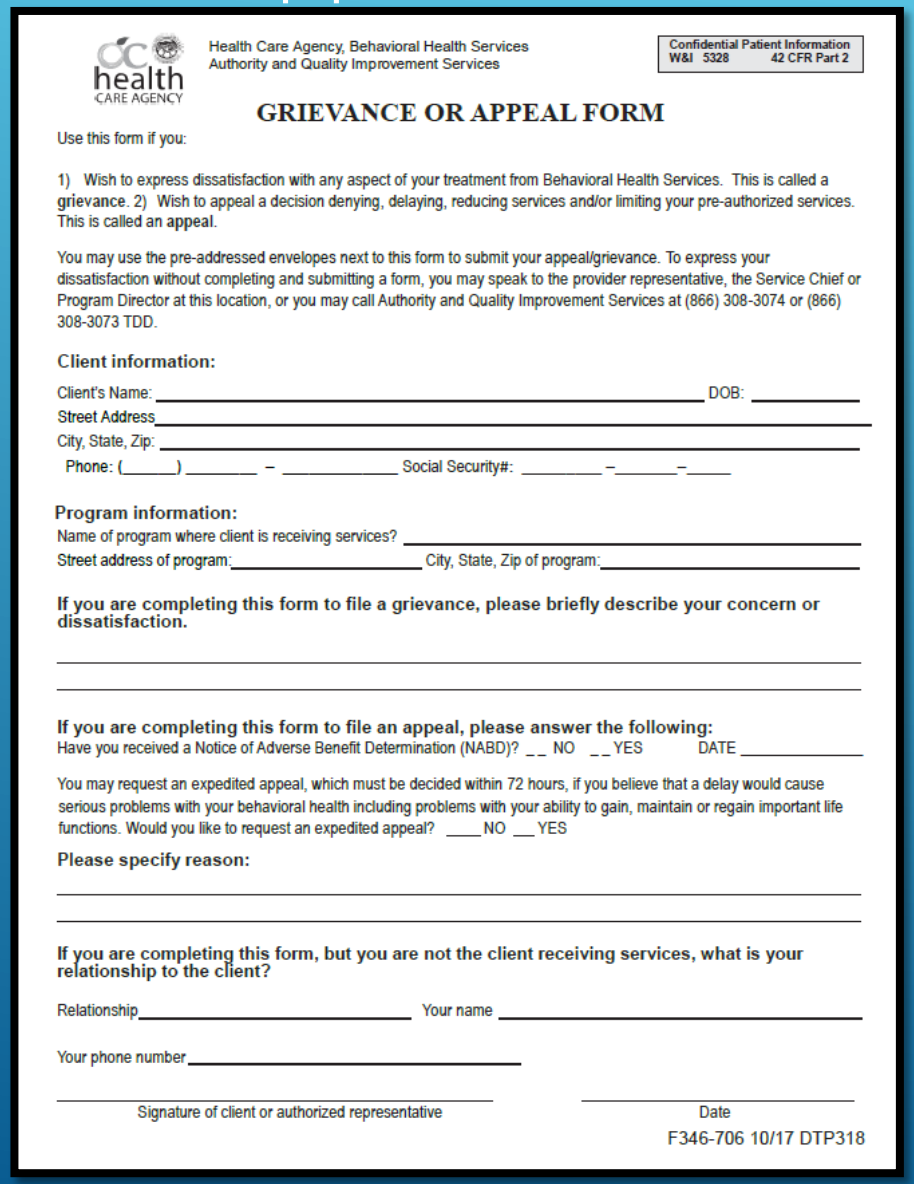
_____ _____
Signature of client or authorized representative Date

F346-706 10/17 DTP318

GRIEVANCE OR APPEAL FORM

- Complete all fields
- Ensure name, address and phone number are correct

Blank Grievance or Appeal Form



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Client information:

Client's Name: _____ DOB: _____
Street Address _____
City, State, Zip: _____
Phone: (_____) _____ – _____ Social Security#: _____ –_____–____

Program information:

Name of program where client is receiving services? _____
Street address of program: _____ City, State, Zip of program: _____

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

_____
_____

If you are completing this form to file an appeal, please answer the following:

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You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? ____NO __ YES

Please specify reason:

_____
_____

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

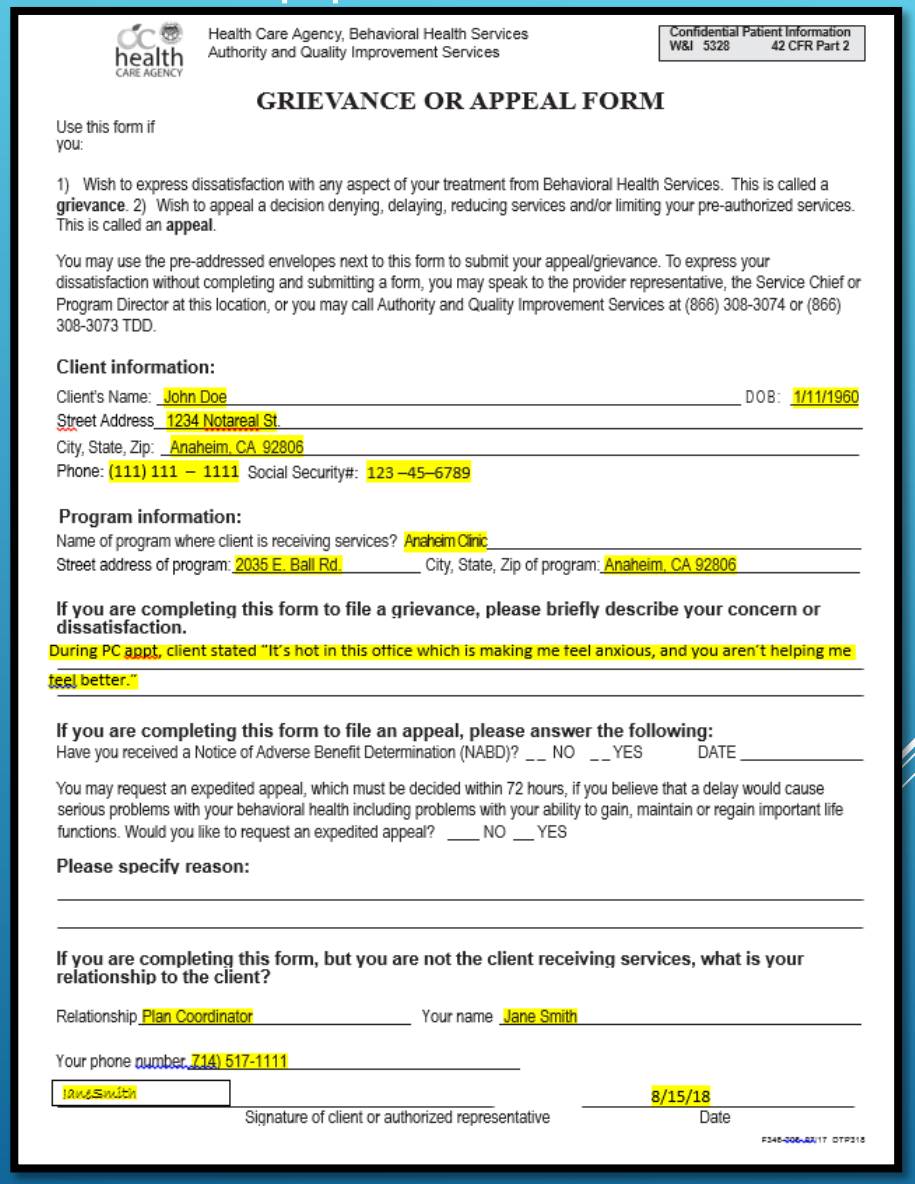
Relationship _____ Your name _____

Your phone number _____

_____ _____
Signature of client or authorized representative Date

F346-706 10/17 DTP318

Completed Grievance or Appeal Form



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Client information:

Client's Name: John Doe DOB: 1/11/1960
Street Address 1234 Notareal St
City, State, Zip: Anaheim, CA 92806
Phone: (111) 111 – 1111 Social Security#: 123 –45–6789

Program information:

Name of program where client is receiving services? Anaheim Clinic
Street address of program: 2035 E. Ball Rd. City, State, Zip of program: Anaheim, CA 92806

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

During PC appt, client stated "It's hot in this office which is making me feel anxious, and you aren't helping me feel better."

If you are completing this form to file an appeal, please answer the following:

Have you received a Notice of Adverse Benefit Determination (NABD)? __ NO __ YES DATE _____

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? ____ NO __ YES

Please specify reason:

_____
_____

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

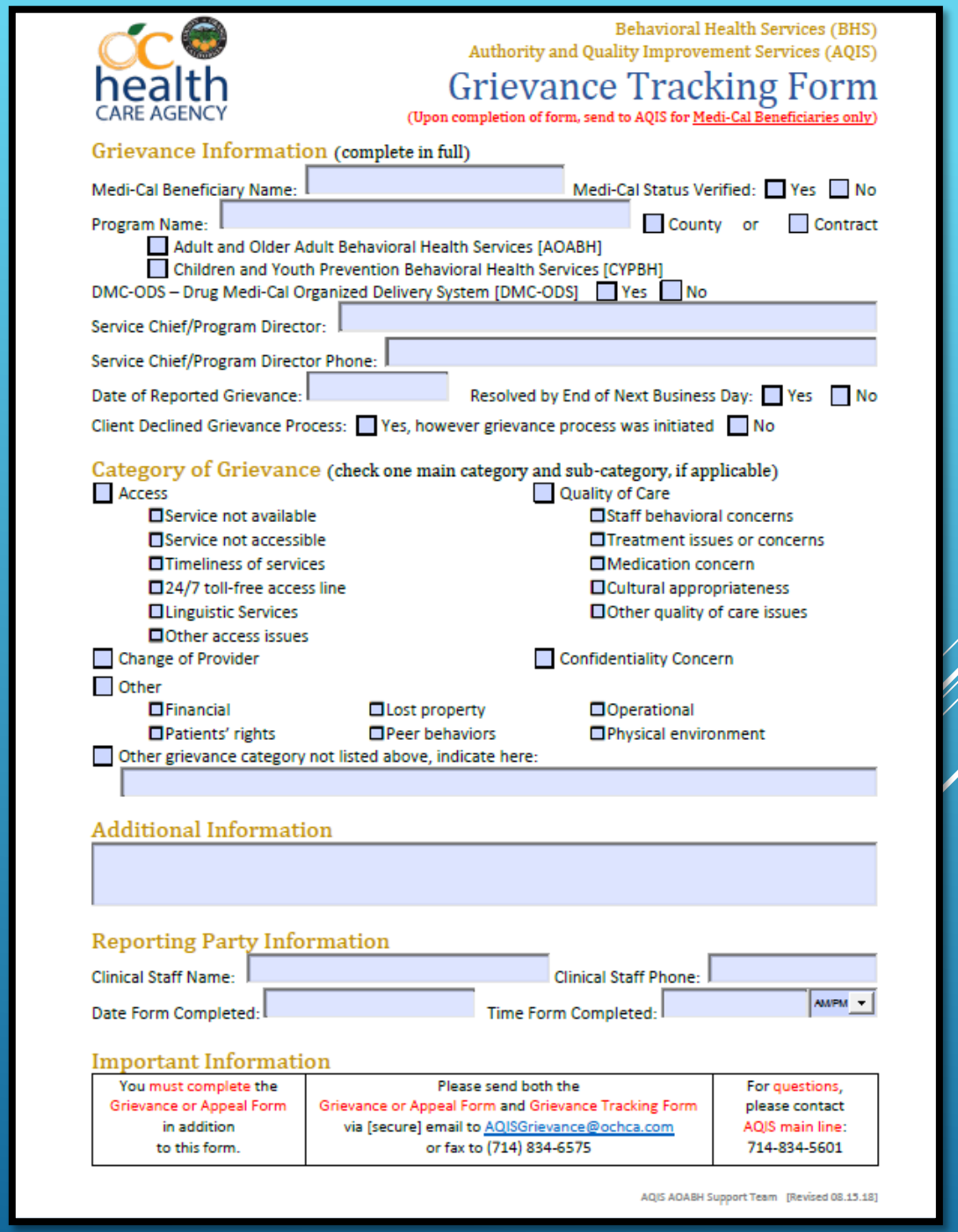
Relationship Plan Coordinator Your name Jane Smith

Your phone number 714) 517-1111

Jane Smith 8/15/18
Signature of client or authorized representative Date

GRIEVANCE TRACKING FORM

- Verify Medi-cal status
- Please complete all fields
- Select category of grievance
- Include any additional information
- Send Grievance or Appeal Form and Grievance Tracking Form via secure email to: AQISGrievance@ochca.com by end of next business day or Fax (714)834-6575



health CARE AGENCY

Behavioral Health Services (BHS)
Authority and Quality Improvement Services (AQIS)

Grievance Tracking Form

(Upon completion of form, send to AQIS for Medi-Cal Beneficiaries only)

Grievance Information (complete in full)

Medi-Cal Beneficiary Name: Medi-Cal Status Verified: ☐ Yes ☐ No

Program Name: ☐ County or ☐ Contract

☐ Adult and Older Adult Behavioral Health Services [AOABH]

☐ Children and Youth Prevention Behavioral Health Services [CYPBH]

DMC-ODS – Drug Medi-Cal Organized Delivery System [DMC-ODS] ☐ Yes ☐ No

Service Chief/Program Director:

Service Chief/Program Director Phone:

Date of Reported Grievance: Resolved by End of Next Business Day: ☐ Yes ☐ No

Client Declined Grievance Process: ☐ Yes, however grievance process was initiated ☐ No

Category of Grievance (check one main category and sub-category, if applicable)

☐ Access
- ☐ Service not available
- ☐ Service not accessible
- ☐ Timeliness of services
- ☐ 24/7 toll-free access line
- ☐ Linguistic Services
- ☐ Other access issues

☐ Quality of Care
- ☐ Staff behavioral concerns
- ☐ Treatment issues or concerns
- ☐ Medication concern
- ☐ Cultural appropriateness
- ☐ Other quality of care issues

☐ Change of Provider

☐ Confidentiality Concern

☐ Other
- ☐ Financial
- ☐ Lost property
- ☐ Operational
- ☐ Patients' rights
- ☐ Peer behaviors
- ☐ Physical environment

☐ Other grievance category not listed above, indicate here:

Additional Information

Reporting Party Information

Clinical Staff Name: Clinical Staff Phone:

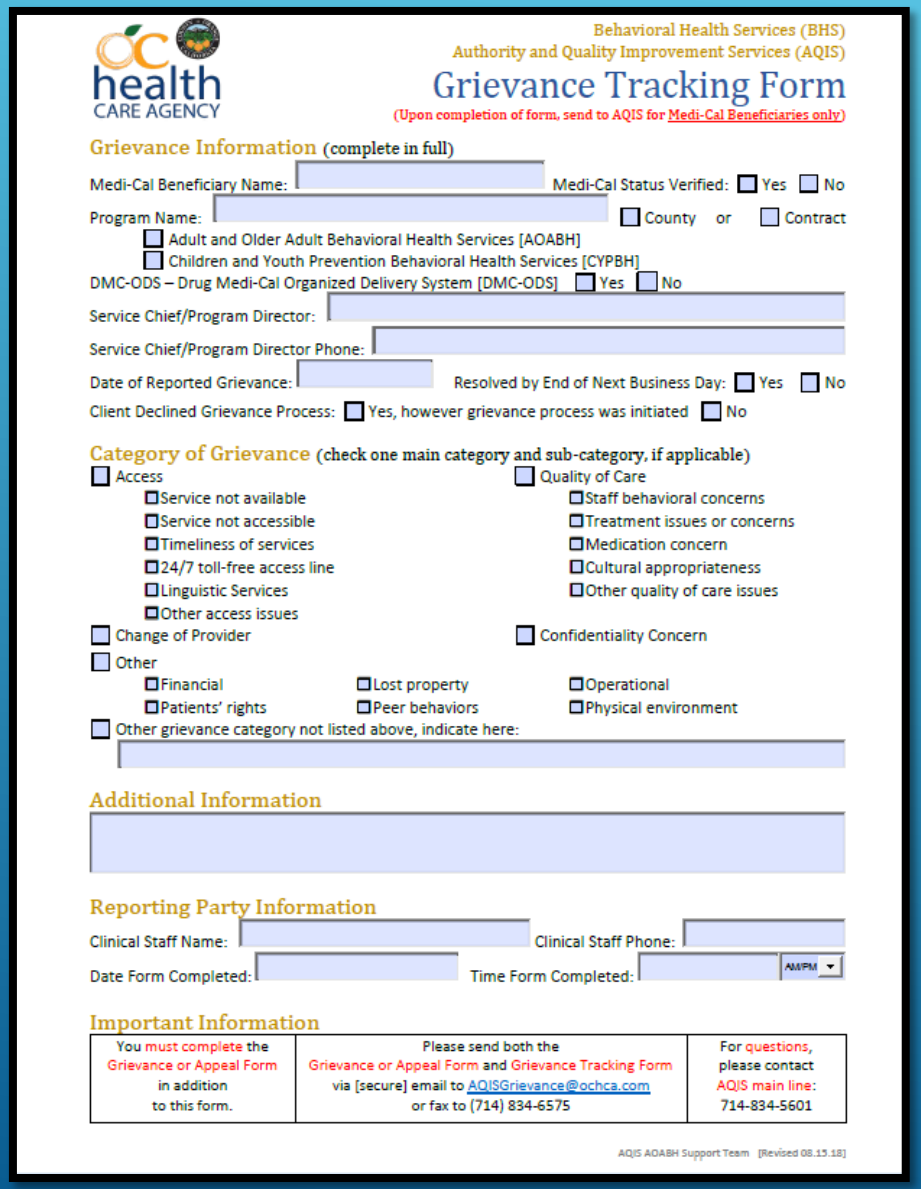
Date Form Completed: Time Form Completed: AM/PM

Important Information

You must complete the Grievance or Appeal Form in addition to this form.	Please send both the Grievance or Appeal Form and Grievance Tracking Form via [secure] email to AQISGrievance@ochca.com or fax to (714) 834-6575	For questions, please contact AQIS main line: 714-834-5601

AQIS AOABH Support Team [Revised 08.15.18]

Blank Grievance Tracking Form



Behavioral Health Services (BHS)
Authority and Quality Improvement Services (AQIS)

Grievance Tracking Form

(Upon completion of form, send to AQIS for Medi-Cal Beneficiaries only)

Grievance Information (complete in full)

Medi-Cal Beneficiary Name: _____ Medi-Cal Status Verified: ☐ Yes ☐ No

Program Name: _____ ☐ County or ☐ Contract

☐ Adult and Older Adult Behavioral Health Services [AOABH]

☐ Children and Youth Prevention Behavioral Health Services [CYPBH]

DMC-ODS – Drug Medi-Cal Organized Delivery System [DMC-ODS] ☐ Yes ☐ No

Service Chief/Program Director: _____

Service Chief/Program Director Phone: _____

Date of Reported Grievance: _____ Resolved by End of Next Business Day: ☐ Yes ☐ No

Client Declined Grievance Process: ☐ Yes, however grievance process was initiated ☐ No

Category of Grievance (check one main category and sub-category, if applicable)

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- ☐ Peer behaviors
- ☐ Physical environment

☐ Other grievance category not listed above, indicate here: _____

Additional Information

Reporting Party Information

Clinical Staff Name: _____ Clinical Staff Phone: _____

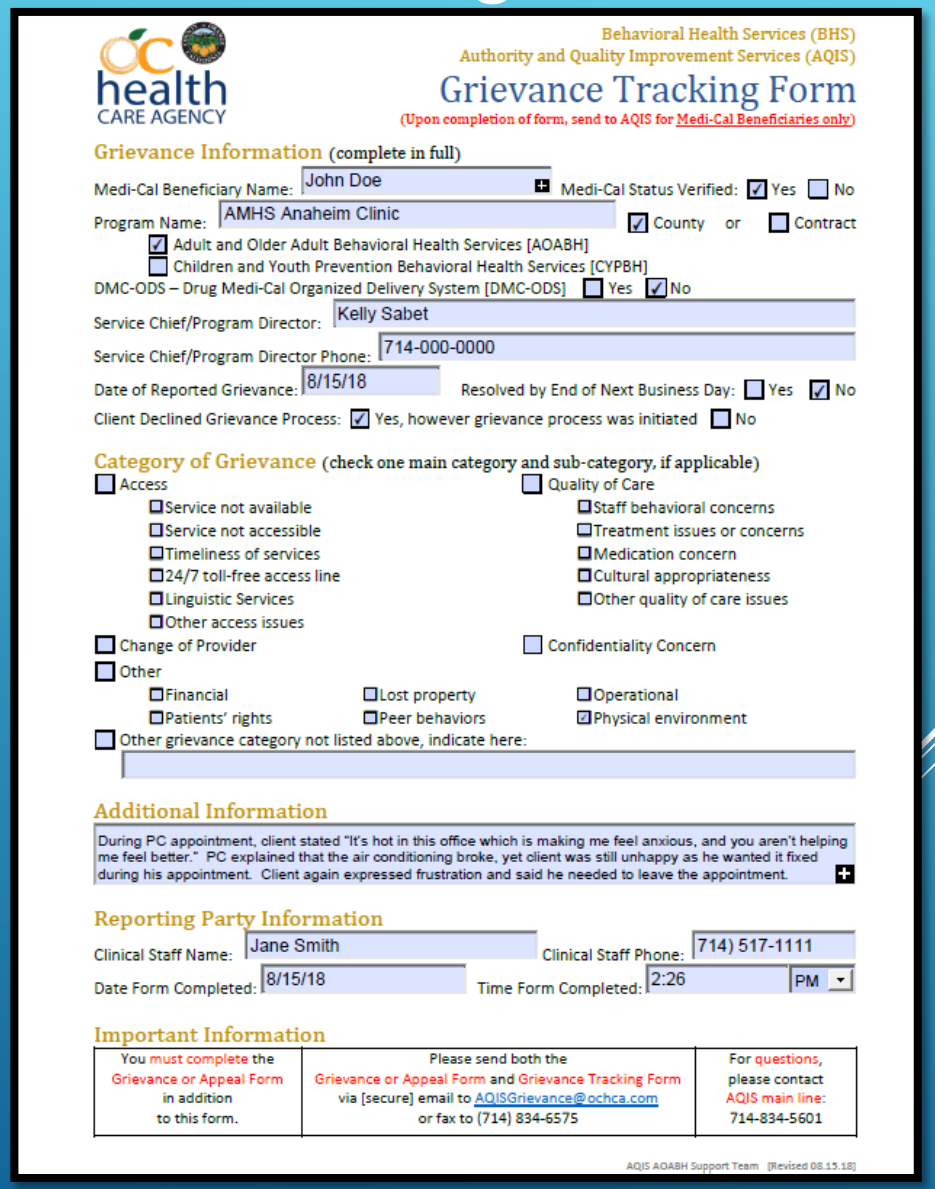
Date Form Completed: _____ Time Form Completed: _____ AM/PM

Important Information

You must complete the Grievance or Appeal Form in addition to this form.	Please send both the Grievance or Appeal Form and Grievance Tracking Form via [secure] email to AQISGrievance@ochca.com or fax to (714) 834-6575	For questions, please contact AQIS main line: 714-834-5601

AQIS AOABH Support Team [Revised 08.15.18]

Completed Grievance Tracking Form



Behavioral Health Services (BHS)
Authority and Quality Improvement Services (AQIS)

Grievance Tracking Form

(Upon completion of form, send to AQIS for Medi-Cal Beneficiaries only)

Grievance Information (complete in full)

Medi-Cal Beneficiary Name: John Doe Medi-Cal Status Verified: ☑ Yes ☐ No

Program Name: AMHS Anaheim Clinic ☑ County or ☐ Contract

☑ Adult and Older Adult Behavioral Health Services [AOABH]

☐ Children and Youth Prevention Behavioral Health Services [CYPBH]

DMC-ODS – Drug Medi-Cal Organized Delivery System [DMC-ODS] ☐ Yes ☑ No

Service Chief/Program Director: Kelly Sabet

Service Chief/Program Director Phone: 714-000-0000

Date of Reported Grievance: 8/15/18 Resolved by End of Next Business Day: ☐ Yes ☑ No

Client Declined Grievance Process: ☑ Yes, however grievance process was initiated ☐ No

Category of Grievance (check one main category and sub-category, if applicable)

☐ Access
- ☐ Service not available
- ☐ Service not accessible
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☐ Other
- ☐ Financial
- ☐ Lost property
- ☐ Operational
- ☐ Patients' rights
- ☐ Peer behaviors
- ☑ Physical environment

☐ Other grievance category not listed above, indicate here: _____

Additional Information

During PC appointment, client stated "It's hot in this office which is making me feel anxious, and you aren't helping me feel better." PC explained that the air conditioning broke, yet client was still unhappy as he wanted it fixed during his appointment. Client again expressed frustration and said he needed to leave the appointment.

Reporting Party Information

Clinical Staff Name: Jane Smith Clinical Staff Phone: 714) 517-1111

Date Form Completed: 8/15/18 Time Form Completed: 2:26 PM

Important Information

You must complete the Grievance or Appeal Form in addition to this form.	Please send both the Grievance or Appeal Form and Grievance Tracking Form via [secure] email to AQISGrievance@ochca.com or fax to (714) 834-6575	For questions, please contact AQIS main line: 714-834-5601

AQIS AOABH Support Team [Revised 08.15.18]

CHARTING AND LOGGING

- Grievance or Appeal forms are NOT to be filed in chart
  - Please remember to follow IT and Office of Compliance Guidelines
- Programs are NOT to complete a tracking log as AQIS will be doing so

WHAT HAPPENS NEXT?

- AQIS will begin the internal workflow

INTERNAL WORKFLOW FOR AQIS: GRIEVANCE REPRESENTATIVE

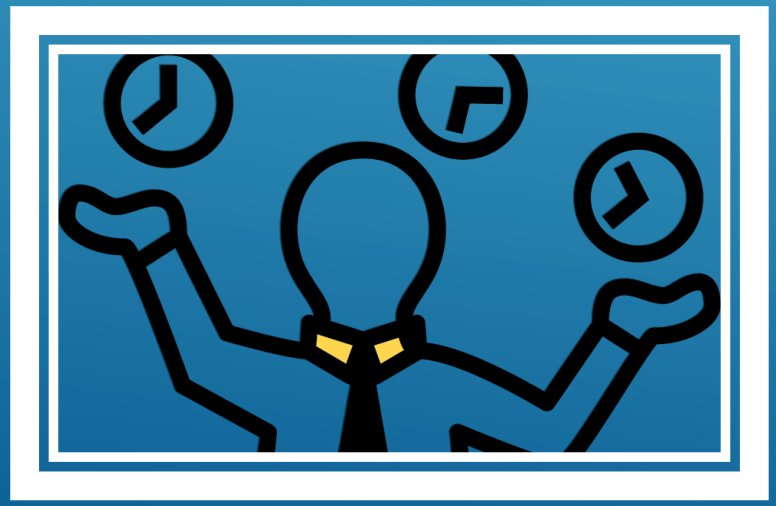
- Date stamp the grievance form with the date the form received
- Develop acknowledgement letter **which identifies the assigned Investigating Representative**
- AQIS Administrative Manager signs letter
- Mail acknowledgement letter to the beneficiary
- Assign initial grievance to an Investigating Representative

INTERNAL WORKFLOW INVESTIGATING REPRESENTATIVE

- Investigating Representative will research the grievance and contact Beneficiary within 2-3 days
- If an Authorized Representative is indicated, an ATD must be obtained and signed by the Beneficiary stating the reason for information disclosed is for the purpose of representing the Beneficiary on a grievance
- Contact Program/Supervisor of the individual being grieved against
- Investigating Representative determines that there is a need for additional information, follow up as needed with Beneficiary/program to resolve the grievance within 90 days

EXCEPTIONS TO THE 90 DAY TIMEFRAME

- Beneficiary can request an extension
- Investigating Representative determines that there is a need for additional information and that the delay is in the Beneficiary's interest, this timeframe may be extended by up to 14 calendar days
- If the grievance is related to the MHP or DMC-ODS decision to extend the timeframe for making an authorization decision, the timeframe for resolution is 30 days



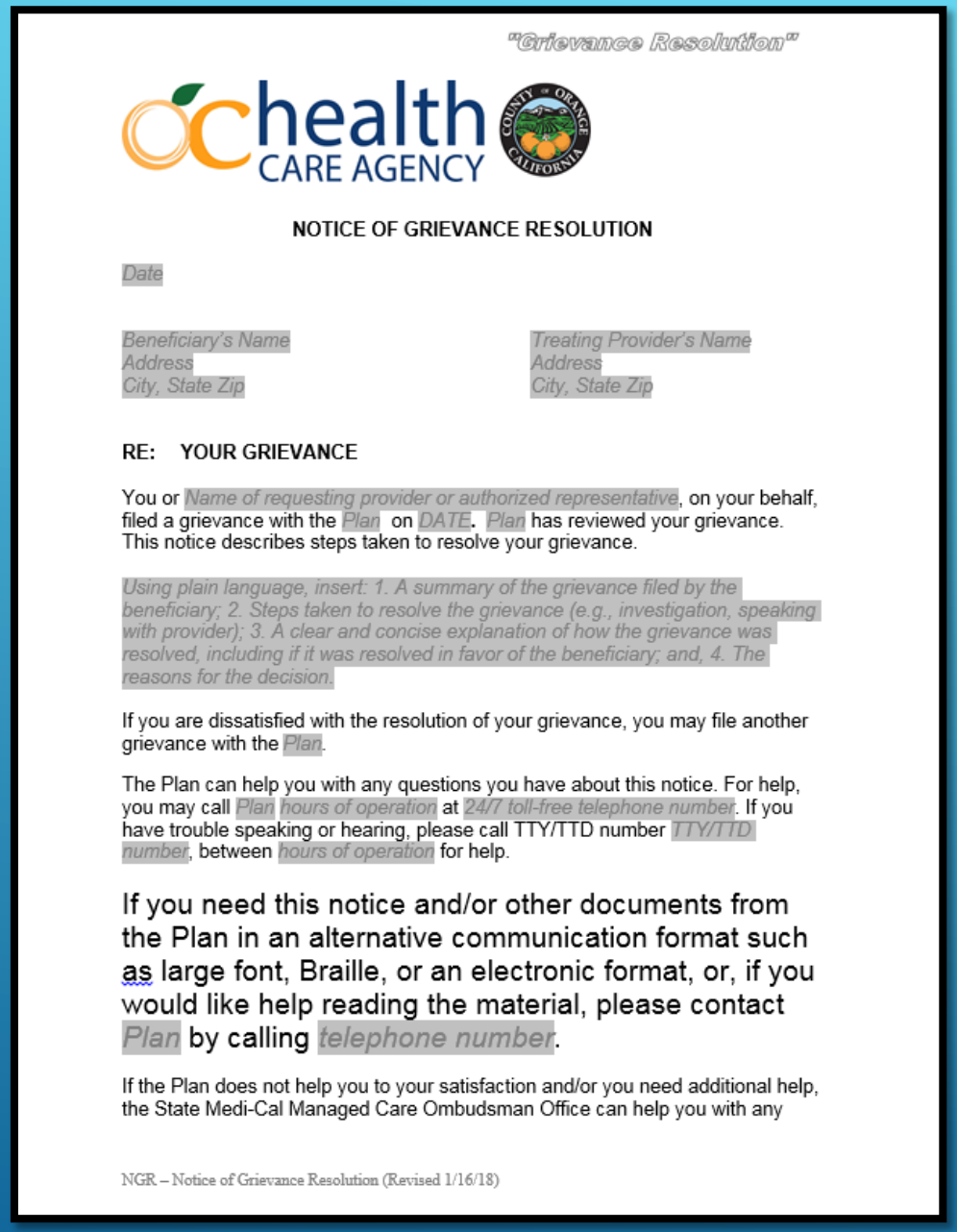
GRIEVANCE NOT RESOLVED WITHIN 90 DAYS

- Make reasonable effort to give the Beneficiary prompt oral notice of the delay
- Prepare a Notice of Adverse Benefit Determination-Delay (NOABD-D) to the Beneficiary. Give the completed NOABD, the Your Rights under Medi-Cal Notice, the Non-Discrimination Notice and the Language Assistance Notice

GRIEVANCE RESOLVED

- Investigating Representative shall complete a Notice of Grievance Resolution (NGR) which **all** parties involved will be listed and CC'd
- AQIS Administrative Manager shall review and approve NGR
- AQIS Office Support staff will mail NGR to the Beneficiary and send secure/encrypted email to all designated parties CC'd

NOTICE OF GRIEVANCE RESOLUTION (NGR)



"Grievance Resolution"

ochealth CARE AGENCY

NOTICE OF GRIEVANCE RESOLUTION

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: YOUR GRIEVANCE

You or *Name of requesting provider or authorized representative*, on your behalf, filed a grievance with the *Plan* on *DATE*. *Plan* has reviewed your grievance. This notice describes steps taken to resolve your grievance.

Using plain language, insert: 1. A summary of the grievance filed by the beneficiary; 2. Steps taken to resolve the grievance (e.g., investigation, speaking with provider); 3. A clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the beneficiary; and, 4. The reasons for the decision.

If you are dissatisfied with the resolution of your grievance, you may file another grievance with the *Plan*.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan hours of operation* at *24/7 toll-free telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Plan* by calling *telephone number*.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any

NGR – Notice of Grievance Resolution (Revised 1/16/18)

"Grievance Resolution"

questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609

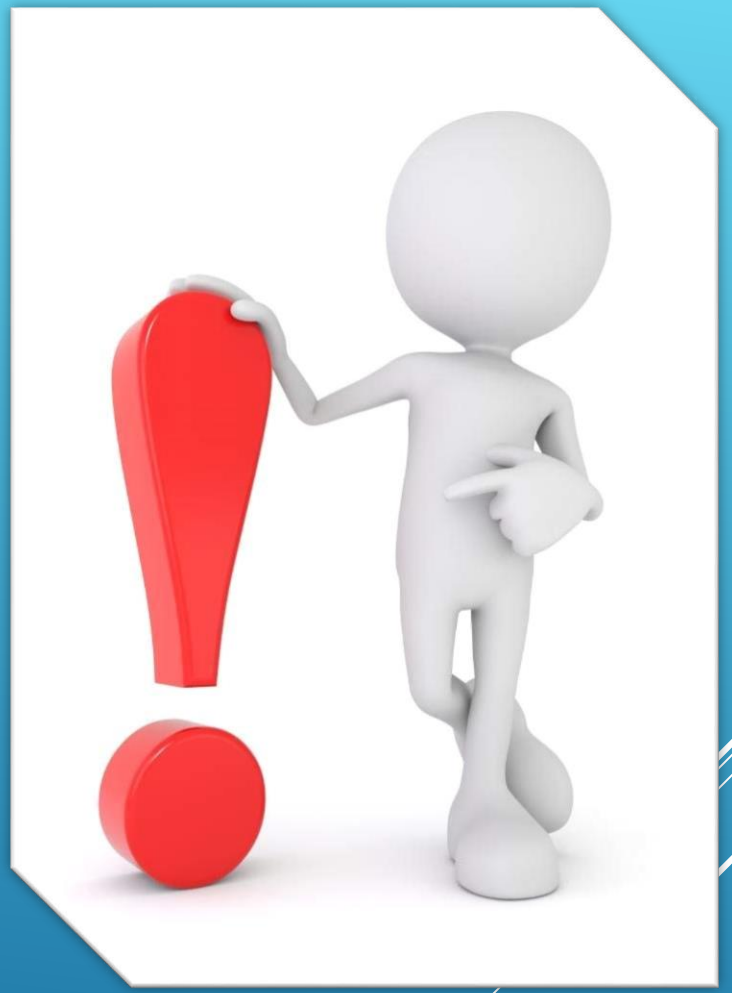
Signature Block

Cc: All Parties involved

NGR – Notice of Grievance Resolution (Revised 1/16/18)

A FRIENDLY REMINDER

- We encourage you to have conversations with your staff if they are named in a grievance
- **No retaliation**



QUESTIONS?

- **AQIS Main Line:**
  - (714)834-5601

- **AQIS Managers:**
  - AOABH/PRAS: Kelly K. Sabet, LCSW,AMII
  - CYPBH: Aida Sanchez-Nunez, LCSW, AMII
  - DMC-ODS: Azahar Lopez, PsyD., AMI

- **Grievance Leads/Primary Contact:**
  - AOABH: Brenda Truong, LCSW
  - CYPBH: Luis Arevalo, Ph.D.
  - DMC-ODS: John Crump, LMFT