Policy Title: **Complaint and Grievance Policy for Health Homes Serving Children**
Policy Number: **HH0013**
Effective Date: April 1, 2021
Last Revised:
Approved By:

Applicable to:
This policy pertains to ALL children and youth enrolled in the New York State Medicaid Health Home Serving Children (HHSC) Program. This includes complaints and grievances filed by/on behalf of children and youth under the 1915(c) Children's Waiver authority, enrolled in a Medicaid Managed Care Plan (MMCP), or Fee-For-Service (FFS).

[**Please Note:** The member or their representative may file complaints and grievances to their Health Home, MMCP, the Independent Entity: Children and Youth Evaluation Services (C-YES), and their Home and Community Based Service (HCBS) provider regarding their respective responsibilities and services. Each entity of the MMCP, C-YES, and the HCBS provider have a process to record and report such complaints and grievances to the New York State Department of Health (the Department). However, any member or their representative may file complaints and grievances to their Health Home (HH) care manager regarding any concern or issue they may have. The HH care managers should reference the MMCP and C-YES policies and procedures as needed to support the member.]

Purpose
This policy addresses the requirements for managing complaints and grievances related to participation in the Health Home Serving Children (HHSC) Program. The complaint and grievance process are limited to those areas that are external to, but not in lieu of, the existing right to request access to the Medicaid Fair Hearing system.

The complaint and grievance procedure may be used by a member, their parent(s), guardian, legally authorized representative, or anyone else on behalf of the member who wishes to file a complaint regarding the provision of services, activities, or benefits by the Health Home (HH) program. A grievance/complaint must be submitted without jeopardizing the member's participation in the HHSC program or the Children's Waiver HCBS eligibility or services for which HHs provide care management.

Types of grievances/complaints include, but are not limited to:
- Any violation of rights,
- Availability of service or ability to receive service,
- Quality of care received and/or whether services are meeting the member's needs,
- Afforded choice of providers,
- Whether crisis or support plans are effective,
- Program eligibility and/or qualifications,
- Whether health and welfare are being maintained, and/or
- Dissatisfaction with services or providers of services.

The NYS Department of Health (Department) requires that each HHSC develops and implements a policy for responding to complaints and grievances raised by the member, parent(s), guardian, or legally authorized representative. A member, parent, guardian, or legally authorized representative may initiate a verbal or written complaint or grievance at any time. All parts of any complaint or grievance, regardless of the filing method, must be documented from intake through resolution.

HHSC must have a quality assurance process in place to ensure that CMA's comply with their policies and procedures.

Definitions

The following definitions are provided as guidance when conducting activities related to the complaint and grievance process:

Appeal
A request to change a previous decision made by the Medicaid Managed Care Plan (MMCP), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) of an adverse benefit determination from either a medical necessity determination or an experimental/investigational action.

Children and Youth Evaluation Service (C-YES)
C-YES is the State-designated Independent Entity who develops and manages the HCBS plan of care for children and youth enrolled in the 1915(c) Children's Waiver who elect to opt out of Health Home care management but still want to receive HCBS.

Children's Waiver of Home and Community Based Services (HCBS)
The 1915(c) Children's Waiver of HCBS requires that each participant receives care coordination for HCBS. Health Home care management provides this care coordination unless the participant opts-out and are managed by C-YES.

Complaint
Dissatisfaction expressed verbally or in writing by or on behalf of a member, other than an appeal or Fair Hearing Rights. Such expressions may include dissatisfaction with the provision of services or other services identified in the member's plan of care. For example: a customer service issue; lack of/dissatisfaction with coordination of care; a long wait in doctor's office; Health Home Care Manager (HHCM) not returning phone calls; HHCMs lack of response to member request for changing HHCM or Care Management Agency (CMA); etc.

Fair Hearing
A Fair Hearing is a chance for an individual to have an eligibility or service decision reviewed by an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance (OTDA), when the individual does not agree with the decision made or thinks it is wrong.

Grievance
A wrong or hardship suffered (real or perceived), which is the grounds of a complaint.

Member
For the purpose of this policy document, whenever '**member**' is used it refers to the child or youth and their parent(s), guardian, or legally authorized representative, unless stated otherwise.

Procedure

During the engagement process, members must be informed of how and where to file a complaint or grievance with the Health Home/C-YES and Health Home care management agency. The Medicaid Help Line (1-800-541-2831) must be provided.

At the time of enrollment, and at a minimum annually thereafter, the HHCM must review the complaint and grievance process with the member, including the care manager's role in assisting to resolve complaints/grievances.

HHSC members may file grievances or complaints at any time regarding their experience (e.g. HH, HHCM, MMCP, HCBS provider or other healthcare/service provider, etc.). A member may file the complaint/grievance verbally or in writing. If a verbal complaint/grievance is made, documentation in the member's file must be made by either progress notes or agency complaint form. A member must be given reasonable assistance in completing a form (such as interpreter services, written/verbal notification, hearing and vision assistance, etc.). A complaint/grievance should contain information about the type of grievances/complaints alleged, name, address, phone number of complainant and location, date, and description of the problem.

Please Note: The Department will require that all complaints/grievance and critical incident are timely documented within the new **Incident Reporting and Management System (IRAMS)** as outlined in the upcoming guidance and manual effective April 1, 2021.

The Department's process for complaints and grievances is not intended to replace the Medicaid Fair Hearing process and therefore, members should be made aware that filing a grievance or a complaint is not a prerequisite or substitute for a Medicaid Fair Hearing. A member must request a Fair Hearing within 60 calendar days from the alleged violation.

Children's Waiver of HCBS

Within the population of children/youth served by the Health Home program, there are a subset of members who are eligible and enrolled in the Children's Waiver. There are additional requirements for Health Home care managers and C-YES regarding how a member is informed about complaints and grievance. During the engagement process, care manager must ensure that all HCBS members are informed of the *Children's Waiver Participant Rights and Responsibilities*, inclusive of how and where to file a complaint or grievance.

Health Homes

Health Homes (HH) must establish policies and procedures for their network CMAs that outline the process for complaints and grievances reported to the Health Home or CMAs:

- How to manage received complaints and grievances
- Documentation and maintaining supporting documents related to the receipt and resolution of complaint and grievances
- Resolution steps taken
- Members satisfaction
- Reporting to the Department

Note: HCBS providers must comply with the *HCBS Provider Complaints and Grievances Policy;* the Health Home or CMA may be involved in the resolution of the complaint or grievance.

The Managed Care Complaint line (1-800-206-8125) is available Monday through Friday 8:45 am to 4:45 pm and can be used for members to file complaints regarding their Managed Care or 1915(c) waiver service provision. This number can also be used to escalate a complaint that was not resolved by an MMCP, HH, C-YES, or HCBS provider to the member's satisfaction. Members may also email their complaints to: managedcarecomplaint@health.ny.gov

Timeframes for Addressing Complaints and Grievances

Health Homes (HH) and HH care management agencies (CMA) must have procedures in place to ensure the timely review and resolution of member's complaints and grievances. The HH and CMA is responsible for creating a process and informing the member of timeframes for addressing verbal or written complaints or grievance. This process must include contacting and updating the member within 72 hours of receiving the complaint or grievance. Response and resolution of the complaint or grievance process cannot exceed 45 calendar days from the receipt of the complaint or grievance. Documentation of the resolution must be in the member's file.

Notification

The HHCM/CMA must notify the lead HH, the Department, and/or other appropriate parties (i.e. multidisciplinary team members) of the complaint or grievance. If the member is not satisfied with the resolution, the CMA must refer the member to the lead HH or the Department.
If a member is not satisfied with a resolution, the complaint/grievance may be escalated to the Medicaid Help Line (1-800-541-2831) within 90 calendar days.

At any point in the complaint and grievance process, the member or their representative may contact the Department or the MMCP for assistance in addressing and resolving a grievance/complaint. This process is not in lieu of requesting a Fair Hearing.

Record Retention

HHs and CMAs are required to retain all records pertaining to complaint and grievance submission and resolution, including a copy of the written or verbal complaint, the action taken to address the complaint or grievance, the resolution, member satisfaction, elevation of investigation needed, and dates of all actions taken and evidence of timelines met (or if not, supporting documentation). Complaint and grievance review, oversight, and resolution are subject to evaluation during Departmental site visits. Data collected may be used to determine if there are any systemic issues that need to be addressed through corrective action plans.

In addition, records must be available upon request for Federal Centers for Medicare and Medicaid Services (CMS), the Department, or the Office of the Medicaid Inspector General (OMIG) audits/reviews.

Please note: The Department will require that all complaints/grievance and critical incident are timely documented within the new **Incident Reporting and Management System (IRAMS)** as outlined in the upcoming guidance and manual. The IRAMS will replace some of the record retention and reporting to the Department requirements.

Training

Policies and procedures must include staff training on the subject of complaint and grievance processes, including but not limited to:

- Purpose of a complaint and grievance system, to include familiarity with associated laws and requirements
- Method for ensuring members are informed of their right to file complaints and grievances, and how to file
- Establishing and maintaining a system to receive, review, investigate, and respond to complaints and grievances received both verbally and in writing, associated timelines, assisting members to file, ensuring appropriate entity is notified and involved in the process, as appropriate (e.g., HH, CMA, MMCPs, HCBS providers, and C-YES)
- Addressing issues with member satisfaction
- Conducting trend analysis and addressing issues identified

- Self-monitoring for system effectiveness, including the use of corrective actions plans
- Reporting requirements

Quality Monitoring and Reporting Requirements

Grievances, complaints, and appeals are part of quality monitoring, oversight, and improvement procedures. Information collected should include but is not limited to:

- The type of complaints and grievances filed
- All complaints and grievances were addressed
- Required timelines were met
- Outcome of investigations
- Resolution provided to member timely and appropriately
- Complaints and grievances elevated due to lack of member satisfaction or significance of issue identified during investigation
- Trends identified
- Corrective action required

Health Home policies and procedures must include a system for monitoring and identifying problematic trends within their network CMAs and provide appropriate interventions when corrective actions are needed. Actions must be taken to minimize the probability of recurrence. Such actions must be documented and available for review by the Department.

Resources

Phone Numbers:

DOH Managed Care Complaint Line: 1-800-206-8125
OHIP Medicaid Help Line: 1-800-541-2831

Websites:

https://www.health.ny.gov/health_care/managed_care/complaints/