Policy Title: **Complaint and Grievance Policy for Home and Community Based Services (HCBS) Providers**
Policy Number: **CW0008**
Effective Date: April 1, 2021
Last Revised:
Approved By:

Applicable to:
This policy pertains to all children and youth receiving Home and Community Based Services (HCBS). This includes complaints and grievances filed by or 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. The HCBS provider should be aware that each entity of the MMCP, C-YES, and Health Homes have a process to record and report such complaints and grievances to the New York State Department of Health (the Department). If a complaint or grievance is reported to an HCBS provider concerning the HHCM/C-YES/MMCP directly, then HCBS providers should reference the HH/C-YES/MMCP policies and procedures as needed to support the member or can contact the Department via the complaint Help Line.]

Purpose
This policy addresses the requirements for HCBS providers in addressing and/or assisting with complaints and grievances. The complaint and grievance process is 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 initiated by a participant, their parent(s), guardian, legally authorized representative, or anyone else on behalf of the participant who wishes to file a complaint regarding the provision of services, activities, programs, or benefits of the Children's Waiver. A grievance/complaint must be submitted without jeopardizing the child/youth's participation in HCBS Children's Waiver or HCBS eligibility or services received.

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 HCBS provider develops and implements a policy for responding to complaints and grievances that may be 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.

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.

Complaint

Dissatisfaction expressed verbally or in writing by or on behalf of a participant, other than an appeal or Fair Hearing Rights. Such expressions may include dissatisfaction with the provision of services or other services identified in the participant's Plan of Care. For example: a customer service issue; lack of/dissatisfaction with coordination of care; a long wait in doctor's office; HCBS provider not returning phone calls; HCBS provider cancelling meetings/sessions; 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

HCBS providers must inform the member during the engagement process how and where to file a complaint or grievance. Additionally, the HCBS provider will verify with the member that their care manager also provided information regarding the *Children's Waiver Participant Rights and Responsibilities*, inclusive of how and where to file a complaint or grievance. The Medicaid Help Line (1-800-541-2831) must be provided.

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

HCBS providers must have a process in place that outlines the HCBS participants rights and explanation of services. HCBS providers should be aware of the information contained within the *Children's Waiver Participant Rights and Responsibilities* and the case manager timeframe for review to help facilitate effective conversations with the child/youth/family and answer any resulting questions they may have throughout the process. (HCBS providers may utilize the *Children's Waiver Participant Rights and Responsibilities* instead of developing their own.)

HCBS participants may file grievances or complaints at any time regarding their experience with services they are receiving. A child/youth/family 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. The child/youth/family 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 complaint/grievance such as name, address, phone number of complainant and location, date, and description of the problem. All reported complaints and grievances to the HCBS provider should be documented and tracked.

Internal systems are needed for HCBS waiver providers to process complaints and grievances registered by participants concerning agency discrepancies in service provision. HCBS waiver providers are required to notify the member's care manager (HHCM or C-YES) and the Medicaid Managed Care Plan (MMCP), if applicable, of any complaint or grievance filed directly to the HCBS waiver provider to ensure coordination of services and review of potential impact upon the Plan of Care. The HHCM/C-YES/MMCP should work together with the HCBS provider to resolve the complaint or grievance of the participant. When a complaint or grievance cannot be resolved, the Department must be notified.

Please Note: The Department will require that all complaints/grievances and critical incidents 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; therefore, HCBS providers should inform participants that filing a grievance or making a complaint is not a prerequisite or substitute for a Medicaid Fair Hearing. A participant must request a Fair Hearing within 60 calendar days from the alleged violation.

Timeframes for Addressing Complaints and Grievances

HCBS providers must have procedures in place to ensure the timely review and resolution of member's complaints and grievances. The HCBS provider is responsible for creating a process and informing the member of timeframes for addressing verbal or written complaint or grievances. 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 HCBS provider must notify the care manager of HH/C-YES, the Department, and/or other appropriate parties (MMCP, multidisciplinary team members) of the complaint or grievance. If the member is not satisfied with the resolution, the HCBS provider must refer the member to 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

The HCBS providers 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 participants 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 participants with filing, ensuring the appropriate entity is notified and involved in the process, as appropriate (e.g., HHCM, MMCP, C-YES)
- Addressing issues with participant 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
- Timely and appropriate resolution provided to participant

- Complaints and grievances elevated due to lack of participant satisfaction or significance of issue identified during investigation
- Trends identified
- Corrective action required

HCBS provider policies and procedures must include a system for monitoring and identifying problematic trends and provide appropriate interventions that 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/