



Beneficiary Protection Training

CONTRA COSTA COUNTY MENTAL HEALTH PLAN

2019

Beneficiary Protection Training

Training Goals and Objectives:

To understand the role of the Patients' Rights Advocate

To understand basic patients' rights

To understand the role of the Ombudsman

To know what a Notice of Adverse Benefit Determination is

To understand our Appeal and Grievance Policy

To know what an Advance Health Care Directive is

Patients' Rights Advocacy

Advocacy is the process of promoting and representing beneficiaries' rights and interests through direct assistance, monitoring, training, and policy review.

Patients' Rights Advocacy

HANDBOOK

Rights for Individuals in Mental Health Facilities

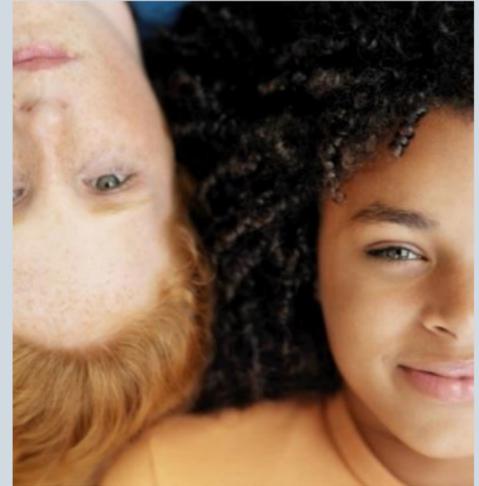
Admitted Under the Lanterman-Petris-Short Act




CALIFORNIA DEPARTMENT OF
Mental Health

Patients' Rights Advocacy

- Based on the beneficiary's expressed interest
- Not a neutral position
- Ensures the statutory and constitutional rights of recipients of mental health services



Patients' Rights Advocacy

What Advocates Do:

1. Investigate and resolve complaints regarding violations or abuse of patients' rights
2. Act as advocate for those unable or afraid to register a complaint
3. Monitor facilities for compliance with patients' rights laws, regulations, and policies
4. Assist staff in ensuring that all beneficiaries are notified of their rights

Patients' Rights Advocacy

What Advocates Do:

5. Act as consultant to mental health professionals
6. Act as liaison between the advocacy program and the State Office of Patients' Rights
7. Represent beneficiaries at inpatient certification review and medication hearings

What They Don't Do:

Advocates do not determine what is most “appropriate” for the beneficiary, or what is in the beneficiary’s “best interest.”

The advocate’s role is to counsel beneficiaries about their options and the implications of those options, and to advocate for the beneficiary’s expressed interest.

Patients' Rights Advocacy

There are legal sanctions for interfering with advocacy activities.

Welfare and Institutions Code § 5550 (e)

Any person or facility found in violation...shall pay a civil penalty, as determined by a court, of not less than one hundred dollars (\$100), or more than one thousand dollars (\$1,000) which shall be deposited in the county general funds.



Patients' Rights Advocacy

Summary of Rights

- All beneficiaries are guaranteed certain treatment rights
- Many rights may NEVER be denied
- In psychiatric facilities, some specific rights may be denied ONLY when GOOD CAUSE exists
- Refer to *"Mental Health Consumer Rights"* poster for more information

Ombudsman

According to Webster's Dictionary, an Ombudsman is:

A person appointed by a legislative body to receive, investigate, and report by private individuals.

The term also means protector or defender of citizens' rights.

Ombudsman

The Ombudsman performs a:

NEUTRAL

CONFIDENTIAL

OBJECTIVE

fact finding inquiry in response to community or individual complaints.

Ombudsman

A bit of history...

- The term comes from a Scandinavian word, where it means “representative.”
- The first public sector Ombudsman was appointed by the Parliament of Sweden in 1809
- The State of Hawaii established the first Ombudsman office in the United States in 1967

Ombudsman

Calls are welcomed from:

Children

Relatives

Foster Parents

Attorneys

Physicians

Therapists

Social Workers

Teachers & other
School Personnel

Members of the Clergy

Law Enforcement

All Community
Organizations

Ombudsman

What Ombudsmen Do:

- Conduct independent and impartial reviews of complaints
- Ensure that policies and practices are consistent with the goals and mission of the Division
- Ensure that individuals receive all medically necessary covered services and information for which plans are contractually responsible
- Ensures individuals are treated fairly, respectfully, and with dignity
- Make referrals and recommendations as appropriate
- Provide information, answer questions, and/or identify staff persons or resources to address issues raised

Ombudsman

What Ombudsmen Do:

- Assure that issues are treated in a reasonable, respectful, and confidential manner
- Facilitate prompt resolutions of complaints in an independent, impartial, objective, and professional manner
- Provide education and “navigation” of the system to callers
- Research agency policies and procedures that may assist in resolving the complaint

Ombudsman

What Ombudsmen Don't Do:

- Have the authority to overturn a court decision or make recommendations to the court
- Investigate matters when appeals or lawsuits are pending against the county
- Conduct personnel and disciplinary matter decision-making, but refers to agency director for appropriate delegation
- Give legal advice
- Ensure implementation of any recommendation made following the Ombudsman investigation

Notice of Adverse Benefit Determination *(NOABD)*

A **Notice of Adverse Benefit Determination** (NOABD) is a form given to the beneficiary which advises them of a determination that has taken place regarding their case. This form also advises the beneficiary about their right to appeal the determination, including their right to request a State Hearing.

Notice of Adverse Benefit Determination

There are 9 types of NOABD's:

1. **Authorization Delay:** Given to a beneficiary when we fail to make a decision about a service request in a timely manner.
2. **Delivery System:** Given to a beneficiary following an assessment when the beneficiary does not meet medical necessity criteria and no services will be provided.
3. **Denial:** Given to a beneficiary when we deny an authorization from one of our providers.
4. **Financial Liability:** Given to a beneficiary when we deny their dispute of financial liability.

Notice of Adverse Benefit Determination

- 5. Grievance/Appeal Resolution:** Given to a beneficiary when a beneficiary has filed a Grievance or Appeal and we have failed to respond in a timely manner.
- 6. Modification:** Given to a beneficiary when we deny a request for a change in treatment, and approve instead a different treatment.
- 7. Payment Denial:** Given to the beneficiary when we deny, in whole or in part, payment for a service post-service delivery.
- 8. Termination:** Given to the beneficiary when a service they are receiving is terminated.
- 9. Timely Access:** Given to the beneficiary when the System Of Care fails to provide services in a timely manner.

Notice of Adverse Benefit Determination

What if I need to send a Notice of Adverse Benefit Determination?

If you have a situation where you believe you may need to send a beneficiary a NOABD, please discuss it with your supervisor or contact the QI Coordinator.

Appeals and Grievances

What is an Appeal?

What is an Expedited Appeal?

What is a Grievance?

What is Contra Costa County's Appeal and Grievance Policies?

What is a State Hearing?



Appeal

An **APPEAL** is a request for review of a problem a beneficiary has with CCMHP or with a provider that involves a denial or changes to services the beneficiary thinks he/she needs.

Expedited Appeal

An **EXPEDITED APPEAL** is an appeal that must have a written decision within 72 hours so as not to jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning.

Appeals

A Medi-Cal beneficiary may ask for an appeal if:

- We did not give them the type or level of mental health service they requested
- We reduced or stopped a service they were receiving
- We failed to process a provider's request for service authorization or to provide mental health services in a timely manner
- We said a private provider mental health service wasn't necessary and didn't pay for it
- We denied their request to dispute financial liability
- They filed a grievance, and we failed to act within required timeframes

An APPEAL can be filed by a Medi-Cal beneficiary only.

The Appeal Process

- Appeals must be filed within 60 days of the date of the Notice Of Adverse Benefit Determination (NOABD). If a NOABD was not issued, there is no deadline for filing an appeal.
- Appeals may be filed orally or in writing. Appeals submitted orally should be called into the Access Line or Quality Improvement Coordinator. Oral appeals must be followed up with a signed, written appeal. Note: *Self addressed envelopes are available at all provider sites.*
- The beneficiary may have another person act on their behalf if the beneficiary signs a Release of Information form for that person to know confidential information.
- The beneficiary may ask staff at the program or the Patients' Rights Advocate for assistance.
- Informing materials and the Request for Appeal or Expedited Appeal Form are required to be posted and easily accessible at all provider sites.
- The beneficiary will receive written notice that their appeal was received

The Appeal Process

- Appeals are confidential and the beneficiary shall not be discriminated against or penalized for filing an appeal.
- Benefits may continue upon request for an appeal within the required timeframe, which is 10 days from the date the Notice of Adverse Benefit Determination was mailed or personally given to the beneficiary.
- Staff reviewing the appeal and making decisions are qualified to do so and not involved in any previous level of review or decision making.
- All appeals are tracked, logged, and reported to DHCS. The QI Program Coordinator is responsible for ensuring that the appeal is assigned for follow-up.
- The beneficiary will be notified of CCMHP's decision in writing.

For a standard appeal, CCMHP has 30 calendar days to make a decision.

For an expedited appeal, CCMHP has 72 hours to make a decision.

Grievance

A **GRIEVANCE** is any complaint other than an APPEAL. All beneficiaries, including both Medi-Cal and non Medi-Cal, can use the county's grievance process.

Any beneficiary may file a grievance if they are dissatisfied with our service.

The Grievance Process

- There is no deadline for filing grievances.
- Grievances may be filed orally or in writing. Grievances submitted orally should be called into the Grievance Line. Oral grievances are not required to be followed up in writing. *Note: Self addressed envelopes are available at all provider sites.*
- The beneficiary may have another person act on their behalf. CCMHP may ask the beneficiary to sign a Release of Information form authorizing CCMHP to release information to that person.
- The beneficiary may ask staff at the program or the Patients' Rights Advocate, for assistance.
- Informing materials and the Consumer Grievance Review Request Form are required to be posted and easily accessible at all provider sites.

The Grievance Process

- The beneficiary will receive written notice that their grievance was received.
- Grievances are confidential and the beneficiary shall not be discriminated against or penalized for filing a grievance.
- Staff reviewing the grievance and making decisions are qualified to do so and not involved in any previous level of review or decision making.
- All grievances are tracked, logged, and reported to DHCS. The QI Program Coordinator is responsible for ensuring that the grievance is assigned for follow-up.
- The beneficiary will be notified of CCMHP's decision in writing.

For grievances, CCMHP has 90 calendar days to make a decision.

State Hearing

A State Hearing is an independent review, conducted by an administrative law judge who works for the California Department of Social Services, to ensure beneficiaries receive the specialty mental health services to which they are entitled under the Medi-Cal program.

State Hearing Rights

- After exhausting local appeals, Medi-Cal beneficiaries may file a State Hearing request with the State.
- The beneficiary has 120 days to request the hearing. The 120 days starts either the day after CCMHP gives the appeal decision notice, or the day after the postmark date of the MHP appeal decision notice.
- If the beneficiary did not receive a Notice of Adverse Benefit Determination, they may file for a State Hearing at any time.
- The beneficiary may ask for Aid-Paid-Pending.
- The beneficiary may ask someone to represent them.
- The State has up to 90 days to decide on the case and notify the beneficiary.
- In some cases, an expedited hearing can be requested.

Advance Health Care Directive



An **ADVANCE HEALTH CARE DIRECTIVE** is a document that describes your physical and mental health care wishes in the event that you are unable to make these decisions on your own.

Advance Health Care Directive

What is your role in providing this information?

- Let the beneficiary know that they have a right to an Advance Health Care Directive
- Let the beneficiary know where they can get the Advance Health Care Directive form



Beneficiary Protection

Contacts

Patients' Rights Advocate

(not a direct County employee)

(925) 293-4942 or (844) 666-0472

Mental Health Access Line

Phone: (888) 678-7277

Grievance Line

Phone: (925) 957-5131

Quality Improvement Coordinator

Phone: (925) 957-5160

Contra Costa County Ombudsman

Phone: (925) 685-2070

DHCS Ombudsman

Phone: (888) 452-8609