Adirondack Health Institute

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POLICY AND PROCEDURE

Title: Complaints Policy

Department: Health Home

Intended Population: Health Home Serving Adults and Children

Effective Date: 9/21/2015

Review Date: 7/1/2020, 7/1/2021

Date Revised: 4/17/2019, 4/1/2021

Purpose of Policy

To describe when and how complaints are to be tracked by Health Home Service Providers, when they should be reported to AHI Health Home (AHIHH), and how these complaints are tracked at AHIHH. This policy and procedure only applies in cases that involve Health Home Candidates and Participants.

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to the AHI Health Home Program Manager.
3. All questions regarding this policy or its implementation may be directed to the AHI Health Home Program Director.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Health Home Complaints Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Health Home Complaints Policy.

Definitions

***AHIHH*:** AHI Health Home; AHI Health Home Program

***Care Management Record System*:** A structured information system, maintained by the AHI Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Program Staff to utilize, as applicable and appropriate to their role in Health Home.

POLICY AND PROCEDURE

Complaint: Any dissatisfaction expressed verbally or in writing by the Health Home Participant or the Health Home Participant's designee, including a parent or guardian, related to the provision of Health Home Care Management services or other services included in the Health Home Participant's plan of care.

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

Enrolled: The status of a Health Home Participant that indicates the person has agreed to participate in Health Home Care Management.

Health Home Candidate: An individual who meets the eligibility criteria for Health Home Care Management.

Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Service Provider for care management. The participant may be in an Enrolled or Outreach Status.

Health Home Service Provider (HHSP): An organization that has a fully executed contract (the "Health Home Service Provider Agreement") with AHI Health Home to provide health home outreach and/or care management services.

NYSDOH: New York State Department of Health

Outreach: The status of a Health Home Participant that indicates the person has not yet agreed to participate in Health Home Care Management. These individuals may or may not have had contact with a care manager.

DOH 5055: Consent to Enroll in Health Home and Information Sharing Consent for Adult Health Home Members

DOH 5200: Consent to Enroll in Health Home for Children's Health Home

DOH 5234: Notice of Decision for Enrollment in Health Home

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.

POLICY AND PROCEDURE

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.

Background

The Complaints Policy at AHI Health Home is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Complaints requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

Policy

It is the policy of AHI Health Home to ensure complaints are tracked and monitored in a manner that prioritizes the efficient and effective delivery of Health Home services and to examine and resolve any negative trends.

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) 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***.***

Upon Enrollment

1. Upon enrollment, Health Home Participants and/or their designees, parent, or guardian as appropriate are provided with a Member Rights and Responsibilities documents as well as a documenting outlining the Health Home Service Provider's complaint Procedure. These documents must be reviewed annually with the member and documented in the Care Management Record.
    a. The Health Home Service Provider (HHSP) may utilize the document in Appendix A for this purpose, branding it with its own logo if desired OR may use a document specific to the nuances of their agency.
    b. At a minimum, the complaint procedure distributed to Health Home Participants and/or their designee, parent, or guardian as appropriate must include:
        i. The agency's procedure for escalating complaints
        ii. The AHI Health Home toll free number
        iii. The NYS Medicaid Helpline
        iv. Contact and procedural information related to state fair hearings through the Office of Temporary Disability Assistance (OTDA).
    c. Health Home Participants and/or their designees, parent, or guardian as appropriate will also receive Notice of Decision for Enrollment in Health Home (DOH 5234). This document

is to be reviewed upon Enrollment into Health Home at the time the prospective Consent to Enroll is signed (DOH 5055 or DOH 5200). A copy of the DOH 5234 in conjunction with the consent to enroll form will be kept in the Health Home Participants Electronic Health Record.

2. This document must be reviewed with, signed by, the Health Home Participant if age 18 or above or by the participant's parent or guardian if under the age of 18 upon enrollment and annually thereafter. The care manager must also sign the document.

Complaints against an agency other than AHI Health Home or the Health Home Service Provider

1. If the complaint is made against an agency other than the HHSP or AHIHH, the care manager will assist the Health Home Participant and/or designees, parent, or guardian as appropriate in escalating the complaint as appropriate with the agency against which the complaint is made. This includes, but is not limited to following the complaint procedure of the agency against which the complaint is made and/or filing a request for a fair hearing.

Complaints against AHI Health Home or the Service Provider

1. An oral complaint that can be resolved immediately by the HHSP shall be considered resolved. The complaint should be tracked and include the information described under section 4b below. No notice needs to be provided to the Health Home Participant.
2. Written complaints to the HHSP or complaints that were not able to be resolved immediately shall be tracked by the HHSP and include, at a minimum, the information described in section 4b below.
3. Complaints made to AHIHH via the toll-free line shall result in a secure e-mail from AHIHH sent to the HHSP working with the Health Home Participant. This e-mail shall be sent within three (3) business days and shall describe the complaint and any steps taken by AHIHH to resolve the complaint.
    a. If the complaint was resolved immediately, no further action will be taken by AHIHH or the HHSP and the matter shall be considered closed.
        i. The complaint shall be documented by both AHI and the HHSP including, at a minimum, the information described under section 4b below.
    b. If the complaint was not resolved immediately, the HHSP's complaint procedure shall be followed.
        i. When the complaint is resolved by the HHSP, the HHSP shall notify the Health Home Participant and/or their designee, parent, or guardian as appropriate via any reasonable method of communication which may include a phone call, face to face interaction, or letter. Notification of the resolution of the complaint shall be disseminated no later than three (3) business days after resolution of the complaint.
        ii. All complaints must be resolved within 45 calendar days from the receipt of the complaint. Documentation of the resolution must be in the member's file.

POLICY AND PROCEDURE

Any complaints that are unable to be resolved by the HHSP shall be reposted to AHI via secure e-mail within three (3) business days

4. Complaints that are determined to be incidents as defined in the NYSDOH's Health Home Monitoring: Reportable Incidents Policies and Procedures (Policy number: HH0005), shall follow the procedures outlined in the HH Incident Reporting and Monitoring Policy and Procedure and shall be reported to AHI within one (1) business day of recognition that the complaint should be classified as an incident.
    a. If a HHSP is unsure of whether a complaint should be classified as an incident, the HHSP should contact AHIHH via phone or secure e-mail, describing the situation within one (1) business day of this concern.
    b. The below information will be tracked for all complaints and must be maintained separately from the Health Home Participants record:
        i. CIN
        ii. Date of Complaint
        iii. Name of Member
        iv. Care Manager
        v. Description of Complaint
        vi. Steps Taken Toward Complaint Resolution
        vii. Member Satisfaction
        viii. Date of Resolution
        ix. Means of Notification of Resolution to Health Home Participant, if applicable

5. HHSPs must self-monitor for trends that negatively impact Health Home Participants.

<u>Additional Requirements for Complaints and Grievances for Youth Enrolled in Home and Community Based Services</u>

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 regarding how a member is informed about complaints and grievance. During the engagement process, the 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.

This section of the 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).

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.

Upon enrollment in the HCBS Waiver the member, parent, or guardian as appropriate are provided with the Children's Waiver Participant: Rights & Responsibilities FAQ as well as the Freedom of Choice form DOH-5276. Please see the *Children's Waiver Participants Rights and Choice Policy* for more details.

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.

During the outreach process, members must be informed of how and where to file a complaint or grievance with the Health Home or 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 Health Home Care Manager (HHCM) must review the complaint and grievance process with the member, including the care manager's role in assisting to resolve complaints/grievances.

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

Members may file grievances or complaints at any time regarding their experience. 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. 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.

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.

POLICY AND PROCEDURE

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.

Quality and Performance

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

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.
- Addressing issues with member satisfaction

POLICY AND PROCEDURE

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

Contact Person: Director, Care Management and Health Home

Responsible Person: Health Home Service Provider (HHSP)

Approved By: Chief Operating and Compliance Officer

Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

APPENDIX A: AHI Welcome Letter

Welcome to Adirondack Health Institute Health Home!

We are excited to welcome you to the Adirondack Health Institute's Health Home program. Health Home is a Medicaid service, not a physical place. **These services are available to eligible Medicaid individuals at no cost to you**. We greatly look forward to collaborating with you and assisting you with access to the care and resources you need to help maintain your health, achieve personal goals, and increase independence and sustainability in these areas.

Through this program, a Care Coordinator will work with you to coordinate and link you to services such as:

- Engaging and retaining care;
- Coordinating and arranging for the provision of services;
- Supporting adherence to treatment recommendations;
- Monitoring and evaluating needs;
  - Such as prevention, wellness, medical, specialist, and behavioral health treatment, care transitions, social and community services, peer supports.
- Addressing social determinants of health such as; safe and affordable housing, food insecurity, access to education and job opportunities, transportation, barriers to accessing medications.

Your primary care coordinator is ______ from __________. They can be reached during normal business hours, Monday – Friday 9am to 4pm, at **518-**_______. A representative from ____________ can be reached 24/7 via phone at ____________.

If you have any concerns about the care coordination services you are receiving, _________leadership team can be reached at ____________; office hours are Monday – Friday 9am to 4pm or in writing to ; ______________________. Or you may call the Medicaid Help Line at 1-800-541-2831.

We hope our program serves you well. If you have any questions or concerns, please call or write. **We will be happy to help you!**

We look forward to serving you!

Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

LOCAL COUNTY DEPARTMENTS OF SOCIAL SERVICES

Clinton County Department of Social Services
13 Durkee Street
Plattsburgh, NY 12901
518-565-3300

Essex County Department of Social Services
7551 Court Street, PO Box 217
Elizabethtown, NY 12932
518-873-3441

Franklin County Department of Social Services
184 Finney Boulevard
Malone, NY 12953
518-481-1888

Hamilton County Department of Social Services
139 White Birch Lane, PO Box 725
Indian Lake, NY 12842
518-648-6131

Saratoga County Department of Social Services
152 West High Street
Ballston Spa, NY 12020
518-884-4148

St. Lawrence Department of Social Services
6 Judson Street Canton, NY 13617
315-379-2111.

Warren County Department of Social Services
1340 State Route 9
Lake George NY, 12845
518-761-6300

Washington County Department of Social Services
383 Broadway
Fort Edward NY, 12828
518-746-2300

Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

MEMBER'S RIGHTS & RESPONSIBILITIES

EACH MEMBER* HAS THE RIGHT TO:

Services:

- ☐ Receive a timely response to requests for help and information.
- ☐ Receive considerate and respectful services.
- ☐ Receive services without regard to race, color, creed, gender, sexual orientation, religion, age, disability, marital status, national or ethnic origin.
- ☐ Take an active part in the planning of services.
- ☐ Receive accurate and up to date information.
- ☐ Refuse services.
- ☐ Terminate services at any time.

Confidentiality:

- ☐ Have all records and information kept private and confidential
- ☐ Receive a copy of, and have explained to you, the HIPAA Notice of Privacy Practices.
- ☐ Provide written, signed consent if information is to be released.
- ☐ Revoke consent at any time.

Feedback:

- ☐ Provide feedback regarding the services you receive, including the right to make a complaint if warranted
- ☐ Utilize the Complaint Procedure if services are not to your satisfaction.
- ☐ Participate in surveys to let the agency know how we can better serve you.

EACH MEMBER* HAS THE RESPONSIBILITY TO:

Services:

- ☐ Schedule appointments before coming in to the office.
- ☐ Keep scheduled appointments.
- ☐ Develop and work towards agreed upon goals.

Confidentiality:

- ☐ Maintain confidentiality of other members.

Agency Policies:

- ☐ Observe agency policies.
- ☐ Abstain from any harassing and/or violent behavior (verbal, written or physical) towards agency staff or members.
- ☐ Treat other members and staff with courtesy and respect.
- ☐ Refrain from being under the influence of alcohol or illegal substances when attending appointments/ events (office visits, home visits, support groups, medical appointments when accompanied by staff, etc.).

Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

COMPLAINT PROCEDURE

When you have a problem, issue, or major difference of opinion about treatment through this agency, you have the right to report your complaint. You may follow the below steps:

1. Contact your/ your child's care manager for assistance in resolving the issue
2. If no resolution can be reached, the member/guardian/designee should inform the care manager that he/she would like to meet with the agency's supervisor of the Health Home program. This meeting will take place within 10 days of request.
3. If you are not satisfied, you may contact the Director of the agency.

You may also contact the below organizations for grievances related to the Health Home program:

AHI Health Home: 1-866-708-2912

New York State Medicaid Helpline: 1-800-541-2831

You may request a State Fair Hearing. A Fair Hearing is a chance for you to tell an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings, why you think a decision about your/your child's/your designee's case made by a local social services agency is wrong. The Office of Temporary and Disability Assistance will then issue a written decision which will state whether the local agency's decision was right or wrong. The written decision may order the local agency to correct the case.

To request a Fair Hearing, you may call 1 (800) 342-3334,
fax the Fair Hearing Request Form to 518-473-6735, or mail it to:
New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
P.O. Box 1930
Albany, NY 12201-1930

Your/your child's care manager will provide you a copy of the Fair Hearing Request Form upon request.

Your/ your child's care manager will assist in connecting you with resources to help you with filing complaints, including requests for Fair Hearings. These resources can include, but are not limited to, hearing and vision assistance and language interpretation.

By signing this form, you understand that you/your child have rights and responsibilities as a Health Home Participant, including the right to make a complaint about the Health Home services received. You will receive a copy of this form once you have signed it.

______________________________	______________________________	____________
Health Home Participant- Print Name Health Home Participant's Parent/Guardian	Health Home Participant- Sign Name Health Home Participant's Parent/Guardian	Date
______________________________	______________________________	____________
Care Manager- Print Name	Care Manager- Sign Name	Date