Section: Customer Services	Policy Name: **Customer Grievance System**	Policy Number: **06.03**
Owner: **Customer Services Manager**	Reviewed By: **Sarah Ameter**	Total Pages: **8**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** **Michigan Mental Health Code**	Final Approval By: *Sarah Ameter*	Date Approved: Dec 9, 2022
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☐ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **MI Health Link** ☐ **CCBHC** ☐ **Other (please specify):** _____	Effective Date: **12/1/22**

Policy: All enrollees have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/ or delivered by Prepaid Inpatient Health Plans (PIHPs) and their participant Community Mental Health Service Programs (CMHSPs). An enrollee of, or applicant for, public mental health specialty services and supports may access several options to pursue the resolution of a grievance or appeal. All policies and procedures related to the grievance, appeals, and second opinion processes are available, upon request, to any customer, provider, or facility rendering service free of charge. Southwest Michigan Behavioral Health (SWMBH) participant CMHSPs will handle and process complaints in ways consistent with the policies set forth by SWMBH.

The Due Process Clause of the U.S. Constitution guarantees that Medicaid enrollees must receive "due process" whenever benefits are denied, reduced, suspended, or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Customers of mental health and substance use disorder services who are Medicaid enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievances and appeals for Medicaid enrollees who participate in managed care:

- State Fair Hearings through authority of 42 CFR 431.200 et seq.

- PIHP Appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid enrollees, as public mental health consumers, have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 2, 7, 7A, 4, and 4A, including:

- Mediation through authority of the Mental Health Code (MCL 330-1206a et seq.)
- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Second Opinion through authority of the Mental Health Code (MCL 330.1705 et seq.)

Southwest Michigan Behavioral Health and its participant CMHSPs will comply with the office of Civil Rights Policy Guidance on the Title VI Prohibition against Discrimination as it affects Persons with Limited English Proficiency (LEP) when they provide written notices to customers and engage in resolution processes. In addition, Southwest Michigan Behavioral Health (SWMBH) and its participant CMHSPs will provide reasonable assistance to persons who have illiteracy, hearing, or visual impairments.

Purpose: To ensure the grievance system for Medicaid enrollee's, to include funding sources: Healthy Michigan Plan (HMP) and Home and Community Based Services (HCBS) going forth, promotes the resolution of the customer's concerns while supporting and enhancing the overall goal of improving quality of care.

Scope: Customer Services

Responsibilities: SWMBH Customer Service Department and delegated entities, as applicable, shall ensure compliance with the standards and guidelines outlined in this policy and guiding documents.

Definitions:

A. Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the PIHP to make an authorization decision.

B. Grievance and Appeal System: the processes the PIHP/CMHSP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

C. Mediation: A confidential process in which a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable resolution. A mediator does not have authoritative decision-making power

Standards and Guidelines:

A. Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs/CMHSPs, that each PIHP/CMHSP has an overall grievance system in place for enrollee's that complies with Subpart F of Part 438.

B. The grievance system must provide Medicaid enrollees:

1. A Grievance Process.
2. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
3. Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PIHP Grievance or Appeal Process, the Enrollee is deemed to have exhausted the PIHP's grievance or appeal process. The Enrollee may initiate a State fair hearing.
4. With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file a Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance on behalf of the Enrollee with written consent, since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

C. Local Grievance Process: SWMBH and its participant CMHSPs/provider shall abide by federal regulations which provide enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. Each SWMBH participant CMHSP shall have a designated staff person serving as Grievance and Appeal Officer as FTE or equivalent that shall be administratively responsible for facilitating resolution of the Grievance.

1. Enrollee Grievances
    a. Must be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
    b. May be filed at any time by the enrollee, guardian, or parent of a minor child or his/her legal representative.
    c. May be filed either orally or in writing.
    d. Access to the State Fair Hearing process respecting Grievances is only available when the PIHP/CMHSP fails to resolve the grievance and provide resolution within 90 calendar days of the date of the request. This constitutes an "adverse benefit determination" and can be appealed using the State Fair Hearing process.
2. For each Grievance filed by an enrollee, SWMBH and CMHSPs are required to:
    a. Acknowledge the receipt of the Grievance according to state and federal requirements and timeframes.
    b. Maintain record of grievances for review by the State as part of its quality strategy.
    c. Assess whether the Grievance is a Recipient Rights issue and provide assistance as needed to file a complaint with the local Office of Recipient Rights.
    d. Coordinate as appropriate with Fair Hearing Officers.
    e. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

f. Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The PIHP/CMHSP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe.

g. Ensure that the individual(s) who make the decisions on the Grievance:

i. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

ii. When deciding a Grievance that involves either (i) clinical issues, or (ii) denial of expedited resolution of an appeal, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

iii. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

h. Submit the written Grievance to appropriate staff including a PIHP/CMHSP administrator with the authority to require corrective action.

i. Provide the enrollee with written notice within 90 calendar days from the date the Grievance was received.

j. The PIHP/CMHSP may extend the grievance resolution and notice timeframe by up to 14 calendar days if the enrollee requests an extension, or if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the enrollee's best interest. If the resolution timeframe is extended, the PIHP/CMHSP must complete all of the following:

i. Make reasonable efforts to give the enrollee prompt notice of the delay;

ii. Within 2-calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if they disagree with the decision; and

iii. Resolve the grievance as expeditiously as the enrollee's health condition requires and not later than the date the extension expires.

k. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and/or limited reading proficiency.)

l. The content of the Notice of Grievance Resolution must include:

i. The results of the grievance process.

ii. The date the grievance process was concluded

iii. The Medicaid enrollee's right to request a State Fair Hearing if the notice of resolution is more than 90 calendar days from the date of the grievance

iv. Instructions on how to access the State Fair Hearing process, if applicable.

D. <u>Appointment of an Authorized Representative</u>

1. An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative when pursuing grievances.

2. With the written consent from the enrollee, the enrollee has the right to have a provider or other authorized representative, acting on the enrollee's behalf, file a Grievance to the PIHP/CMHSP, or request a State Fair Hearing.
3. In the event the enrollee appoints a representative, the grievance request must include:
    a. A statement that the enrollee is authorizing the representative to act on his or her behalf, and a statement authorizing disclosure of individually identifying information to the representative;
    b. The enrollee's signature and date of making the appointment; and
    c. A signature and date of the individual being appointed as representative, accompanied by a statement that the individual accepts the appointment.
4. Punitive action may not be taken by the PIHP against a provider who acts on the customer's behalf with the customer's written consent to do so or who supports the customer's grievance.
5. A provider may not charge a customer for representation in filing a grievance.
6. If a grievance is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the enrollee, the 90 day time frame beings on the date an authorized representative document is received by the PIHP/CMHSP. The PIHP/CMHSP must notify the enrollee that an authorized representative form or document is required and that the request will not be considered until the appropriate documentation is received. "Third party" is defined as including, but not being limited to: health care Providers.
7. When a request for a grievance is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation upon SWMBH's/CMHSP's request, SWMBH/CMHSP must make, and document, its reasonable efforts to secure the necessary documentation. SWMBH/CMHSP will not undertake a review until or unless such documentation is obtained.
8. For expedited requests, SWMBH/CMHSP will ensure that expedited requests are not inappropriately delayed due to missing documentation for appointment of a representative.

E. <u>Record Keeping Requirements</u>

1. SWMBH and its participant CMHSPs/provider are required to maintain records of enrollee grievances for review by State staff as part of the State quality strategy and the PIHP/CMHSP Memorandum of Understanding regarding service expectations and responsibilities. A PIHP/CMHSP record of each Grievance must contain, at a minimum:
    a. general description of the reason for the Grievance;
    b. The date received;
    c. The date of each review, or if applicable, the review meeting;
    d. The resolution at each level of the Grievance, if applicable;
    e. The date of the resolution for each Grievance;
    f. Name of the covered person for whom the Grievance was filed.
2. PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.
3. Grievance records just be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

4. The SWMBH QAPI Department and Quality Management Committee will review data related to access to services, complaints, and satisfaction with special attention paid to both the customer and client (State of Michigan) perceptions of these topics. In all other documentation (SWMBH QAPI Plan) access, complaints, and satisfaction will refer to both customer and client assessment when available.
    a. The SWMBH QMC will review Grievance member data at least annually, but usually quarterly to identify trends, or areas of improvement.

F. Reporting Requirements
1. Each PIHP/CMHSP provider entity shall adhere to applicable Grievance requirements of this policy.
2. The CMHSP shall
    a. Maintain logs of all grievances for Medicaid enrollees and report them to the PIHP according to the PIHP/CMHSP Memorandum of Understanding
3. The PIHP shall:
    a. Monitor, track, and trend all Grievance requests and dispositions.

G. Mediation
1. A recipient or identified representative must be offered an opportunity to request mediation to resolve a dispute between the recipient/representative and the PIHP/CMHSP or other service provider under contract with the CMHSP related to planning and providing services or supports to the recipient.
2. A recipient or identified representative has a right to have medication services provided by a neutral third party contracted through and paid for by the Michigan Department of Health and Human Services.
    a. A mediator must be an individual trained in effective mediation technique and mediator standard of conduct. A mediator must be knowledgeable in the laws, regulations, and administrative practices relating to providing behavioral health services and supports. The mediator must not be involved in any manner with the dispute or with providing services or supports to the recipient.
3. The PIHP/CMHSP or service provider shall provide notice to a recipient/representative, of the right to request and access mediation at the time services or supports are initiated and at least annually after that. When the PIHP/CMHSP's local dispute resolution process, local appeals process, or state Medicaid fair hearing is requested, notification of the right to request mediation must also be provided to the recipient/representative.
4. The PIHP/CMHSP or service provider involved in the dispute must participate in mediation if mediation is requested.
5. A request for mediation must be recorded by a mediation organization, and mediation must begin within 10 business days after the recording. Mediation does not prevent a recipient/representative from using another available dispute resolution option, including, but not limited to, the PIHP/CMHSP's local dispute resolution process, the local appeals process, the state Medicaid fair hearing, or filing a recipient rights complaint. A mediation organization shall ascertain if an alternative dispute resolution process is currently ongoing and notify the process administrator of the request for mediation. The parties may agree to voluntarily suspend other dispute resolution processes, unless prohibited by law or

precluded by a report of an apparent or suspected violation of rights delineated in the Mental Health Code.

6. Mediation must be completed within 30 days after the date the mediation was recorded unless the parties agree in writing to extend the mediation period for up to an additional 30 days. The mediation process must not exceed 60 days.
7. If the dispute is resolved through the mediation process, the mediator shall prepare a legally binding document that includes the terms of the agreement. The document must be signed by the recipient/representative and a party with the authority to bind the service provider according to the terms of the agreement. The mediator must provide a copy of the signed document to all parties within 10 business days after the end of the mediation process. The signed document is enforceable in any court of competent jurisdiction in this state.
8. If the dispute is not resolved through the mediation process, the mediator must prepare a document that indicates the dispute could not be resolved. The mediator shall provide a copy of the document to all parties within 10 business days after the end of the mediation process.

H. DIFS

1. SWMBH/CMHSPs will cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of the "Patient's Rights to Independent Review Act" (MCL 550.1901-1929).

References:

A. MDHHS/PIHP Contract: General Requirements, (B) Customer Service Standards and (L) Grievance and Appeals Process for Beneficiaries
B. MDHHS Appeal and Grievance Resolution Processes Technical Requirement
C. Medicaid Managed Care Regulations: 42 CFR 431.200, 42 CFR 438.10, 42 CFR 438.228, 42 CFR 438.400-410, 42 CFR 438.416-424
D. Michigan Mental Health Code: Chapters 2, 7, 7A, 4, and 4A. (330.1206a, 330.1409, 330.1705)

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	12/1/22	SWMBH	New Grievance Systems Policy (previously combined with Appeals)	Heather Woods

06.03 Customer Grievance System

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