Section: Customer Services	Policy Name: **Customer Grievance Systems & Second Opinions**	Policy Number: **06.04**
Owner: **Customer Services Manager**	Reviewed By: **Sarah Ameter**	Total Pages: **16**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** **Michigan Mental Health Code**	Final Approval By: *Sarah Ameter*	Date Approved: Jul 26, 2021
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** ☐ **Other (please specify):** _____	Effective Date: **4/1/21**

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 7, 7A, 4, and 4A, including:

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

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. Adverse Benefit Determination: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to make a standard authorization decision within required timeframes; or (v) the failure to act within the required timeframes for the standard resolution of Grievances and Appeals.

B. Appeal: A review at the local level of an adverse benefit determination.

C. 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.

D. State Fair Hearing: Impartial state level review of an enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge.

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 and appeal system in place for enrollee's that complies with Subpart F of Part 438.

B. The grievance system must provide Medicaid enrollees:

1. An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
2. A Grievance Process.
3. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
4. Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
5. Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PIHP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
6. The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
7. With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a State Fair Hearing on behalf of the Enrollee 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. Service Authorization Decisions: When a Medicaid service authorization is processed (initial request or continuation of service delivery) SWMBH and its participant CMHSPs/providers must provide the enrollee written service authorization decision within specified time frames and as expeditiously as the enrollee's health condition requires. The service authorization must meet the requirements for either standard authorization or expedited authorization:

1. Standard Authorization: Notice of the authorization decision must be provided as expeditiously as the enrollee's health condition requires and no later than 14 calendar days following the receipt of a request for a service.
    a. If the enrollee or provider requests an extension; or if SWMBH and its participant CMHSPs/provider justifies (to the state agency upon request) a need for additional information and how the extension is in the enrollee's best interest, SWMBH and its participant CMHSPs/provider may extend the 14 calendar day time period by up to 14 additional calendar days.
2. Expedited Authorization: In cases which the provider indicates, or SWMBH and its participant CMHSPs/provider determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum

function, SWMBH and its participant CMHSPs/provider must make an expedited authorization decision and provide notice of the decision as expeditiously as the enrollee's health condition requires, and no later than 72 hours after receipt of the request for service.

a. If the enrollee or provider requests an extension; or if SWMBH and its participant CMHSPs/provider justifies (to the state agency upon request) a need for additional information and how the extension is in the enrollee's interest, SWMBH and its participant CMHSPs/provider may extend the 72 hour time period up to 14 calendar days.

3. When a standard or expedited authorization of service decision is extended, SWMBH and its participant CMHSPs/provider must make reasonable efforts to give the member prompt oral notice of the delay. SWMBH and participant CMHSPs/providers will, within 2 calendar days, give the member written notification of the reason for the decision to extend the time frame and inform the enrollee of the right to file an grievance if he or she disagrees with that decision. The PIHP/CMHSP must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

D. Notice of Adverse Benefit Determination: SWMBH and its participant CMHSPs/providers are required to provide timely and "adequate" notice of any Adverse Benefit Determination.

1. An Adverse Benefit Determination must be provided to an enrollee when a service authorization decision constitutes an "action" by authorizing a service in the amount, duration, or scope less than currently authorized, or the service authorization is not made timely. In these situations, SWMBH and its participant CMHSPs/provider must provide an Adverse Benefit Determination containing additional information to inform the enrollee of the basis for the action the PIHP/CMHSP has taken or intends to take and the process available to appeal the decision.
2. Notice of Adverse Benefit Determination includes:
    a. The notice of action to the enrollee must be in writing and 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.) and CFR 438.404.
    b. The requesting provider must be provided notice of any decision by the PIHP/CMHSP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. 42 CFR 438.210(c).
    c. Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
    d. Description of Adverse Benefit Determination made;
    e. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
    f. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity

criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

g. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing if the appeal decision upholds the original adverse action.

h. If the utilization review function is not performed within part of an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce or terminate a service occurring outside of the person centered planning process or individualized plan of services process still constitutes an action, and requires a written notice of action.

i. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;

j. Notification of the Enrollee's right to have current benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination");

k. Description of the procedures that the Enrollee is required to follow in order to exercise any of these appeal rights; and

l. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

3. The Adverse Benefit Determination must be either Adequate or Advance:
   a. Adequate Notice of Adverse Benefit Determination is a written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, or a denial of payment for services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect.
   b. Advance Notice of Adverse Benefit Determination is a written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least 10 calendar days prior to the proposed effective date.
4. There are limited exceptions to the advance notice of Adverse Benefit Determination requirement. SWMBH and its participant CMHSPs/provider may mail an adequate notice of adverse benefit determination, not later than the date of action to terminate, suspend or reduce previously authorized services, if:
   a. The PIHP/CMHSP has factual information confirming the death of the enrollee
   b. The PIHP/CMHSP receives a clear written statement signed by the enrollee that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information
   c. The enrollee has been admitted to an institution where he/she is ineligible under Medicaid for further services

d. The enrollee's whereabouts are unknown, and the post office returns PIHP/CMHSP mail directed to him/her indicating no forwarding address
e. The PIHP/CMHSP establishes with MDHHS that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth
f. A change in level of health/medical care is prescribed by the enrollee's physician
g. The date of the action will occur in less than 10 calendar days, in accordance with CFR 483.15(b)(4)(ii) which provides exceptions to the 30 day notice requirements for long-term nursing facilities.
h. The notice involves an adverse determination made with regard to the preadmission screening requirement of section 1919(e)(7) of the Act
i. SWMBH and participant CMHSPs may shorten the period of advance notice to 5 days before the date of action if:
    i. There are facts indicating that action should be taken because of probable Fraud by the enrollee.
    ii. The facts have been verified, is possible through secondary sources.

5. The Adverse Benefit Determination must be mailed within the following timeframes:
    a. At least 10 calendar days before the date of an action to terminate, suspend, or reduce previously authorized covered service(s) (Advance)
    b. At the time of the decision to deny payment for a service (Adequate)
        i. For more information on Denial of Payment, see SWMBH Claims Policy: "Paper Claims Control" and Procedure: "Non-Network Denial Notification".
    c. Within 14 calendar days of the request for a standard service authorization decision to deny or limit services (Adequate)
    d. Within 72 hours of the request for an expedited service authorization decision to deny or limit services (Adequate)
    e. The PIHP is able to extend the standard (14 calendar day) or expedited (72-hour) service authorization timeframes for up to an additional 14 calendar days if either the enrollee or the provider requests the extension; or if the PIHP can show that there is a need for additional information and how the extension is in the enrollee's best interest.
    f. For service authorizations not reached within the specified timeframes, on the date that the timeframes expire.

E. <u>Reinstatement or Continuation of Medicaid Services</u>

1. SWMBH and its participant CMHSPs/provider must continue Medicaid services previously authorized while the local level appeal and/or State Fair Hearing are pending if:
    a. The enrollee or provider files the appeal within 60 calendar days from the date of the Adverse Benefit Determination; and
    b. The enrollee files the request for continuation of benefits timely, on or before the latter of: 10 calendar days from the date of the notice of Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination; and
    c. The appeal involves the termination, suspension, or reduction, of previously authorized services; and

d. The services were ordered by an authorized provider; and
e. The period covered by the original authorization has not expired.
f. If the enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

2. If services are continued or reinstated while the appeal or State Fair Hearing is pending they must continue until:
   a. The enrollee withdraws the appeal or request for State Fair Hearing; or
   b. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal; or
   c. A State Fair Hearing office issues a hearing decision adverse to the Enrollee.
   d. The authorization expires or authorization service limits are met

F. Payment of Continued or Reinstated Medicaid Services

1. If SWMBH and its participant CMHSPs/provider, or the MDHHS Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, SWMBH and its participant CMHSPs/provider, or the State of Michigan must pay for those services in accordance with State Policy and regulations.
2. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.
3. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements.

G. State Fair Hearing Appeal Process

1. SWMBH and its participant CMHSPs/provider shall comply with federal regulations providing a Medicaid enrollee the right to an impartial review (Fair Hearing) by a state level Administrative Law Judge, of an action of a local agency or its agent, in certain circumstances:
   a. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination
   b. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals
2. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State or PIHP, and not extend any timeframes or disrupt continuation of benefits).

3. SWMBH and its participant CMHSPs/provider shall not limit or interfere with an enrollee's freedom to make a request for a State Fair Hearing.
4. Enrollees are given 120 calendar days from the date of the applicable notice of resolution to file a request for a Fair Hearing.
5. The PIHP is required to continue benefits, if the conditions described in Section E: Reinstatement or Continuation of Medicaid Services are satisfied, and for the durations described therein.
6. If the enrollee, or representative, requests a Fair Hearing not more than 10 calendar days from the date of the notice of action and the enrollee or his/her representative requests the services continue, the PIHP/CMHSP must reinstate the Medicaid services until disposition of the hearing by the Administrative Law Judge
7. If the Medicaid enrollee's services were reduced, terminated or suspended without advance notice, the PIHP/CMHSP must reinstate services to the level before the action.
8. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP 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 to the MDHHS Administrative Tribunal using the State Fair Hearing process.
9. The parties to the State Fair Hearing include the PIHP/CMHSP, the enrollee and his or her representative, or the representative of a deceased enrollee's estate.
10. Expedited hearings are available.
11. A Recipient Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities
12. Detailed information and instructions for the Fair Hearing process can be found on the MDHHS website at: www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html
    a. Or through the Department of Licensing and Regulatory Affairs: http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html
13. Southwest Michigan Behavioral Health (SWMBH) and its participant CMHSPs/provider will coordinate and/or conduct the Fair Hearings for Medicaid enrollees of the PIHP/CMHSP.

H. Local Appeal Process

1. SWMBH and its participant CMHSPs/provider shall comply with federal regulations to provide a Medicaid enrollee the right to a local level appeal of an Adverse Benefit Determination. The enrollee, or representative of the enrollee, may file an appeal with the designated staff person serving as Grievance and Appeals Officer under the following conditions:
    a. The enrollee has 60 calendar days from the date of the Adverse Benefit Determination to request a local appeal.
    b. The enrollee must file an expedited appeal request within 10 days of the Adverse Benefit Determination.
    c. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests an expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. Oral inquiries seeking to appeal an Adverse Benefit

Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

d. The Medicaid enrollee may file an appeal with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating local appeals.

e. The PIHP/CMHSP is required to continue/reinstate services if the conditions described in Section D: Reinstatement or Continuation of Medicaid Services are satisfied, and for the durations described therein.

2. When a Local Appeal is requested, SWMBH and its participant CMHSPs/provider shall:

a. 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.

b. Acknowledge the receipt of each appeal.

c. Maintain a record of appeals for review by the PIHP/CMHSP Performance Improvement Program and Customer Services Department, or by the State as part of its quality strategy.

d. Ensure that the individual(s) who make the decisions on appeals:

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

ii. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, 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.

e. Provide the enrollee, or representative with:

i. Reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. SWBMH and partner CMHSPS shall inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals;

ii. Opportunity before and during the appeals process to examine the enrollee's case file, including medical records , other documents or records, and any new or additional evidence considered relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals;

iii. Opportunity to include, as parties to the appeal, the enrollee's and his or her representative or the legal representative of a deceased enrollee's estate;

iv. Provide the enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

3. Notice of Resolution Requirements:
    a. The PIHP/CMHSP must provide written notice of the resolution of the appeal and must also make reasonable efforts to provide oral notice of an expedited resolution.
    b. Enrollee notice of 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.
    c. The content of the notice of resolution must include the results of the appeal and the date it was completed
    d. When the appeal is not resolved wholly in favor of the enrollee, the notice of resolution must also include notice of the enrollee's:
        i. right for a Medicaid enrollee to request a State Fair Hearing and how to do so;
        ii. right to request benefits while the State Fair Hearing is pending, if requested and how to make that request; and
        iii. potential liability for the cost of those benefits if the Hearing decision upholds the PIHP's Adverse Benefit Determination
4. The Notice of Resolution must be provided within the following timeframes:
    a. Standard Appeal Resolution: The PIHP must resolve the appeal and provide notice of resolution to the affected parties as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days from the day the PIHP receives the appeal
    b. Expedited Appeal Resolution: If granted, the PIHP must resolve the appeal and provide written notice of resolution to the affected parties no longer than 72 hours after the PIHP/CMHSP receives the request for expedited resolution of the appeal.
        i. An expedited appeal resolution is available when the PIHP/CMHSP determines (for a request from the enrollee) or the provider indicates (in making the request on behalf of, or in support of the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function
    c. If the PIHP/CMHSP denies a request for expedited resolution of an appeal it must:
        i. Transfer the appeal to the timeframe for standard resolution or no longer than 30 days from the date the PIHP receives the appeal;
        ii. Make reasonable efforts to give the enrollee prompt oral notice of the denial;
        iii. Resolve the appeal as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days; and
        iv. 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.
    d. The PIHP/CMHSP may extend the notice of resolution 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 interest. If the resolution timeframe is extended, the PIHP/CMHSP must complete all 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 appeal as expeditiously as the enrollee's health condition requires and not later than the date the extension expires.

I. 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 for using the State Fair Hearing process.
2. For each Grievance filed by a enrollee, SWMBH and CMHSPs are required to:
   a. Acknowledge the receipt of the Grievance.
   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. 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.

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

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

i. 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.

j. 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.)

k. 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.

J. <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 appeals and 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 an Appeal or Grievance to the PIHP/CMHSP, or request a State Fair Hearing.
3. In the event the enrollee appoints a representative, the appeal or 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 or appeal. .
5. A provider may not charge a customer for representation in filing a grievance or appeal.
6. If a grievance or appeal 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 30 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. For expedited requests, SWMBH/CMHSP will ensure that expedited requests are not inappropriately delayed.
8. When a request for a grievance or appeal 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.

K. Record Keeping Requirements

1. SWMBH and its participant CMHSPs/provider are required to maintain records of enrollee appeals and 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 or Appeal must contain, at a minimum:
    a. general description of the reason for the Grievance or Appeal or Second Opinion;
    b. The date received;
    c. The date of each review, or if applicable, the review meeting;
    d. The resolution at each level of the Appeal or Grievance, if applicable;
    e. The date of the resolution for each Appeal or Grievance;
    f. Name of the covered person for whom the Grievance or Appeal 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 and appeal 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 and Appeal member data at least annually, but usually quarterly to identify trends, or areas of improvement.

L. Reporting Requirements

1. Each PIHP/CMHSP provider entity shall maintain logs of any and all denials of services to Medicaid enrollee's. Each PIHP/CMHSP provider entity shall adhere to applicable Grievance and Appeals and Second Opinion requirements of this policy.
2. The CMHSP shall
    a. Maintain logs of all denials of services for Medicaid enrollees and report them to the PIHP according to the PIHP/CMHSP Memorandum of Understanding
    b. Document all Medicaid enrollee requests for Second Opinions in the identified tracking system.
3. The PIHP shall:
    a. Monitor, track, and trend all denials, State Fair Hearing, Grievance, Appeal, and Second Opinion requests and dispositions.

M. Second Opinions

1. Medicaid and Non-Medicaid enrollees have rights to a Second Opinion review under the authority of the State of Michigan Mental Health Code and the Medicaid Managed Care Regulations. The Second Opinion review process may be requested for denial of inpatient hospitalization and for denial of initial PIHP/CMHSP services under sections 409 and 705 of the Michigan Mental Health Code. The process of notification of rights to a Second Opinion is delegated to each CMHSP.
2. For each denial of inpatient care or eligibility for PIHP/CMHSP service, at the time of the denial, the PIHP/CMHSP is required to provide the enrollee with written notice of the rights to a Second Opinion Process. The notice shall contain all information as identified in this policy. The Notice must indicate that the enrollee is entitled to request a Second Opinion and the process for doing so.
    a. For the denial of inpatient care under Section 409 of the Michigan Mental Health Code, the individual may request a second opinion from the executive director. The executive director shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within 3 days, excluding Sundays and legal holidays, after the executive director receives the request. If the conclusion of the second opinion is different from the conclusion of the preadmission screening unit, the executive director, in conjunction with the medical director, shall make a decision based on all clinical information available. The executive director's decision shall be confirmed in writing to the individual who requested the second opinion, and the confirming document shall include the signatures of the executive director and medical director or verification that the decision was made in conjunction with the medical director. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide appropriate referral services.
    b. For the denial of eligibility for PIHP/CMHSP under Section 705 of the Michigan Mental Health Code, If an applicant for community mental health services has been denied mental health services, the applicant, his or her guardian if one has been appointed, or the applicant's parent or parents if the applicant is a minor may request a second opinion of the executive director. The executive director shall secure the second

opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist. The process should follow standard or expedited timeframes, as outlined in this policy for appeals, as the circumstances warrant.

3. Second Opinions are made available at no cost to enrollees, from a qualified health professional within the network or outside the network if a qualified health professional is not available within the network under section 438.206 (b) of the Medicaid Managed Care Regulations.

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. Michigan Mental Health Code: Second Opinions, 330.1409 and 330.1705
D. 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

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	1/1/15	SWMBH		
2	4/24/15	SWMBH		
3	1/16/17	SWMBH		
4	3/26/18	SWMBH		
5	10/1/18	SWMBH		
6	4/1/19	Definitions, References Standards and Guidelines: C2, D1/2c, E1, F3/12/13, G1d/2/4b/4c, H1c/2fi/2i/2j	Updated per Managed Care Regulations and MDHHS Contract FY19	Heather Woods
7	4/1/20	References, Standards/ Guidelines: A, C, E1e-f; H3a-d; H4b-d; I1d; I2c-j; M2b	Managed Care Regulations and MDHHS/PIHP Contract FY20	Heather Woods
8	6/25/21	References, Standards and Guidelines: C2a, C3, D2a/d/g/j/k, D4e-g/I, D5e-f, E1c, E2c-d, H1a/b/d, H2e, J4/6, K1e, K2-3	Updated contract references. Updated language per contract clarifications.	Heather Woods

06.04 Customer Grievance Systems Second Opinions

Final Audit Report 2021-07-26

Created:	2021-07-26
By:	Erin Peruchietti (erin.peruchietti@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAzVpDghu1mxQJnW1--t8mHU9wAKjsbgyw

"06.04 Customer Grievance Systems Second Opinions" History

Document created by Erin Peruchietti (erin.peruchietti@swmbh.org)
2021-07-26 - 6:42:18 PM GMT- IP address: 104.159.231.26

Document emailed to Sarah Ameter (sarah.ameter@swmbh.org) for signature
2021-07-26 - 6:42:44 PM GMT

Email viewed by Sarah Ameter (sarah.ameter@swmbh.org)
2021-07-26 - 7:00:01 PM GMT- IP address: 104.47.56.126

Document e-signed by Sarah Ameter (sarah.ameter@swmbh.org)
Signature Date: 2021-07-26 - 7:00:07 PM GMT - Time Source: server- IP address: 71.82.81.69

Agreement completed.
2021-07-26 - 7:00:07 PM GMT