VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
POLICIES & PROCEDURES

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I. Purpose and Background

All beneficiaries 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 affiliate Community Mental Health Service Programs (CMHSPs). A beneficiary of, or applicant for, public mental health specialty services and supports, may access several options to pursue the resolution of a grievance or appeal. Van Buren Community Mental Health Authority (VBCMH) will handle and process complaints in ways consistent with the policies set forth by the PIHP. VBCMH and the PIHP share in and have overlap in responsibilities for appropriately handing grievances and appeals; in this procedure that shared responsibility is shown by the use of PIHP/CMHSP rather than using just VBCMH. 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. PIHP/CMHSP will handle and process complaints in ways consistent with the policies set forth by PIHP/CMHSP.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health customers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an appeal**.** Any other type of complaint is considered a grievance**.**

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries 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 Beneficiaries Grievance and Appeal System provides a process to help protect Medicaid Beneficiaries due process rights.

According to 42 CFR 438.408, SWMBH must resolve each grievance and appeal, and provide notice, as quickly as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in 42 CFR 438.408.

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

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local Appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.
- Second Opinion through authority of 42 CFR 438.206 et. seq.

All public mental health and substance abuse customers also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the "Code") Chapters 2, 7, 7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Mediation through authority of the Mental Health Code (MCL 330-1206a et seq.)
- Second Opinion through authority of the Mental Health Code (MCL 330.1705)
- Recipient Rights complaints through the authority of the Administrative Rules for Substance Abuse Service Programs in Michigan 325.14301 et seq.
- PHIP/CMHSP 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, PIHP/CMHSP will provide reasonable assistance to persons who have illiteracy, hearing or visual impairments.
- VBCMH will comply with all contractual language with the MDHHS (specifically Attachment C6.3.2.1) specifically changing how the CMHSP Local Dispute Resolution Process for Non-Medicaid beneficiaries is handled.

II. Definitions

Adverse Benefit Determination: A decision that adversely impacts a Medicaid and Non-Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the receipt of a standard request for service.

- Failure to make an expedited service authorization decision within 72 hours after receipt of a request for expedited service authorization.
- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by VBCMH.
- Failure of VBCMH to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
- Failure of VBCMH to resolve expediated appeals and provide notice within 72 hours after a request for an expedited appeal.
- Failure of VBCMH to resolve grievances and provide notice within 90 calendar days of the date of the request.
- Denial of a request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial responsibility.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as **"B3"** waiver services. These services are a set of approved flexible services that are offered to beneficiaries in lieu of Medicaid State Plan services, and for which Medicaid capitated funds may be used to pay under the authority of the Section (A)(1)(a) of the Social Security Act and approved for use via Michigan's 1915(b) waiver by the federal Centers for Medicare and Medicaid Services.

Adequate Notice of Adverse Benefit Determination: Written notice advising the beneficiary of a decision to deny or limit authorization of Medicaid services and Non-Medicaid services requested. This notice shall be provided to the beneficiaries on the same date the Adverse Benefit Determination takes effect.

Advance Notice of Adverse Benefit Determination: Written notice advising the beneficiary of a decision to reduce, suspend or terminate Medicaid and Non-Medicaid services that are currently being provided. This notice shall be provided or mailed to the Medicaid beneficiary at least 10 calendar days prior and 30 calendar days prior for the Non-Medicaid beneficiary to the proposed date the Adverse Benefit Determination is to take effect

Appeal: A review at the local level of an Adverse Benefit Determination as defined above.

Authorization of Services: The processing of requests for initial and continuing services delivery.

Beneficiary: An individual who has been determined to be eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of the PIHP and/or the CMHSP services

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by a beneficiary or the beneficiary's provider, when the time necessary for the standard resolution process could seriously jeopardize the beneficiary's life, physical or mental health or ability to attain, maintain, or regain maximum function. If it is the beneficiary that is requesting the expedited review, PIHP/CMHSP shall determine if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, PIHP/CMHSP shall grant the request.

Grievance: Medicaid and Non-Medicaid beneficiary's expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but not limited to, (quality of care or service provided, aspects of interpersonal relationships between the service provider and beneficiary, failure to respect the beneficiary's rights regardless of whether remedial action is requested or the beneficiary's dispute regarding an extension of time proposed by the PHIP/CMHSP to make a service authorized decision.

Grievance Process: Impartial local level review of a Medicaid and Non-Medicaid beneficiary's grievance.

Grievance and Appeals System: The processes the PIHP/CMHSP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as processes to collect and track information about them.

Mediation Services: 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 solution. A mediator does not have authoritative decision-making power.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Resolution: Written statement of the PIHP/CMHSP of the resolution of a Grievance or Appeal, which must be provided to the beneficiary.

Recipient Rights Complaint: Written or verbal statement by a beneficiary, or anyone acting on behalf of the beneficiary, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Second Opinion: The process of having a second qualified person (clinician, doctor) assess a case to determine if they agree with the opinion or recommendation of the original staff.

Service Authorization: PIHP/CMHSP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an

amount, duration, or scope less than requested, all as required under applicable law, including but not limited to.

State Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge.

III. Grievance and Appeal System General Requirements

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs/CMHSPs, that each PIHP/CMHSP has grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438. Section V.C.2 of Contract Attachment C6.3.2.1 between MDHHS and CMHSP requires the CMHSP to ensure there is a grievance system in place for Non-Medicaid beneficiaries that complies with MDHHS Contract Attachment C6.3.2.1.

A. The grievance and appeals system must provide Medicaid beneficiaries:
    1. An Appeal process (one level only) which enables beneficiaries to challenge an Adverse Benefit Determination made by the PIHP/CMHSP or its agents.
    2. A grievance process.
    3. The right to concurrently file an Appeal of an Adverse Benefit Determination and 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/CMHSP level Appeal.
    5. Information that if the PIHP/CMHSP fails to adhere to notice and timing requirements as outlined in PHIP/CMHSP Grievance and Appeal Process, the beneficiary is deemed to have exhausted the PIHP/CMHSP's grievance and appeals process. Then, the beneficiary may initiate a State Fair Hearing.
    6. The right to request, and have, Medicaid covered benefits continued while the PIHP/CMHSP Appeal and/or the State Fair Hearing is pending.
    7. With the written consent from the beneficiary, the right to have a provider or other authorized representative, acting on the beneficiary's behalf, file an Appeal or Grievance to the PIHP/CMHSP or request a State Fair Hearing. The provider may file a grievance or request for a State Fair Hearing on behalf of the beneficiary since the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by the PIHP/CMHSP against a provider who acts on the beneficiary's behalf with the beneficiary's written consent to do so.

B. The grievance system must provide Non- Medicaid beneficiaries:
    1. Notice and Review of Rights must be provided 30 calendar days in advance whenever services already in the service plan are being reduced, suspended, or terminated unless this change is currently authorized: is coming from recommendation by the treating psychiatrist or a request from the beneficiary or their legal entity. If requested by psychiatrist or beneficiary, a change in services can begin as soon as it can be made possible.

2. An Appeal process for challenging a Notice and Review of Rights taken by the PIHP/CMHSP.
3. A grievance process.
4. The right to request, and have, their current benefits continued while a PIHP/CMHSP appeal is pending.
5. The right to request an Alternative Dispute Resolution Process within 10 calendar days from the date of the appeal resolution.

C. Service Authorization Decisions

When a Medicaid service authorization is processed (initial request or continuation of service delivery) PIHP/CMHSP must provide the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary'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 that denies or limits services, notice must be provided to beneficiaries14 calendar days following the receipt of a request for a service.
   - If the beneficiary requests an extension or if the PIHP/CMHSP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's best interest; the PIHP/CMHSP may extend the 14-calendar daytime period by up to 14 additional calendar days.
2. Expedited Authorization**:** In cases which the provider indicates, or the PIHP/CMHSP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP/CMHSP must make an expedited authorization decision and provide notice of the decision that denies or limits services within 72 hours after receipt of the request for expedited authorization decision.
   - If the beneficiary requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP/CMHSP may extend the 72-hour time period by up to 14 calendar days.
3. When a standard or expedited authorization of ~~d~~decision timeframe is extended, not at the request of the beneficiary, the PIHP/CMHSP must make reasonable efforts to give beneficiary prompt oral notice of the delay. PIHP/CMHSP will, within 2 calendar days, provide the beneficiary written notice of the reason for the decision to extend the time frame, and inform the beneficiary 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 beneficiary's health condition requires and no later than the date the extension expires.

D. Notice of Adverse Benefit Determination

PIHP/CMHSP is required to provide timely and "adequate" notice of any Adverse Benefit Determination.

1. An Adverse Benefit Determination must be provided to a beneficiary when a service authorization decision constitutes an "action" by authorizing a service in

the amount, duration, or scope other than requested or less than currently authorized, or the service authorization is not made timely. In these situations, PIHP/CMHSP must provide an Adverse Benefit Determination containing additional information to inform the beneficiary of the basis for the action PHIP/CMHSP has taken or intends to take and the process available to appeal the decision.

a. 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.

b. If the utilization review function is not performed within 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 still constitutes an action and requires a written notice of action.

2. The Notice of Adverse Benefit Determination requirements include:
   a. The beneficiary notice must be in writing and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by beneficiaries and potential beneficiaries and meets the needs of those with language format and content limited English proficiency and/or limited reading proficiency) and CFR 438.404.
   b. 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 utilization control procedures.
   c. Description of Adverse Benefit Determination the PIHP/CMHSP has made or intends to make.
   d. The reason(s) for the Adverse Benefit Determination, including 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. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits
   e. Notice of the beneficiary's right to request on Appeal of the adverse benefit determination, including information on exhausting the PIHP/CMHSP single local appeals process, and the right to request a State Fair Hearing, thereafter.
   f. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal.
   g. Notification of the beneficiary's right to have benefits continue 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 beneficiary may be required to pay the costs of continued services (only required when providing Advanced Notice of Adverse Benefit Determination).

- PHIP/CMHSP has no defined circumstances that would require a beneficiary to repay the cost of the continued services during an Appeal as long as the "Reinstatement or Continuation of Medicaid Services" (see section E) qualifications are met.

h. Description of the procedures that beneficiaries are required to follow in order to exercise any of these appeal rights.

i. An explanation that the beneficiary may represent himself/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 beneficiary of a decision to deny or limit authorization of Medicaid services requested, or denial of payment for services requested and the reasons why. The PIHP/CMHSP must mail the notice within timeframes identified in the Code of Federal Regulations (CFR) and written in an easily understood manner.
   b. Advance Notice of Adverse Benefit Determination**:** is a written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed 10 calendar days for Medicaid beneficiaries and 30 calendar days for Non-Medicaid beneficiaries before the proposed effective date the Adverse Benefit Determination takes effect.
4. There are limited exceptions to the advance notice of Adverse Benefit Determination requirement. PIHP/CMHSP 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 verified confirming the death of the beneficiary.
   b. The PIHP/CMHSP receives a clear and written statement signed by the beneficiary that he/she no longer wishes services (per 42CFR 321.213(b)(1)); or that gives information that requires termination or reduction of services and indicates that the beneficiary understands that this must be the result of supplying that information.
   c. The beneficiary has been admitted to an institution where he/she is ineligible (under Medicaid) for further services.
   d. The beneficiary's whereabouts are unknown, and the post office returns PIHP/CMHSP mail directed to the beneficiary indicating no forwarding address.
   e. The PIHP/CMHSP establishes that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
   f. A change in the level of medical care is prescribed by the beneficiary's physician.
   g. The notice involves an adverse determination made with regard to the prescreening screening requirements of section 1919(e)(7) of the SSA.
   h. The date of the action will occur in less than 10 calendar days.
   i. CMHSPs have facts (preferably verified through secondary sources) indicating that action should be taken because of probably fraud by the enrollee. In this

case, the PIHP/CMHSP may shorten the period of advance notice to 5 calendar days before the date of action.

5. The Adverse Benefit Determination must be mailed within the following timeframes:
   a. At least 10 calendar days before for the proposed effective date for beneficiaries with Medicaid and 30 calendar days before for the proposed effective date for beneficiaries of Non-Medicaid services to terminate, suspend, or reduce previously authorized /currently provided Medicaid service(s) (Advance)
   b. For denial of payment for services requested but not currently provided, notice must be provided to the enrollee at the time of the action affecting the claim. (Adequate)
   c. Within 14 calendar days of the receipt of request for a standard service authorization decision to deny or limit services (Adequate)
   d. Within 72 hours of the receipt of request for an expedited service authorization decision to deny or limit services (Adequate).
   e. The PIHP/CMHSP is able to extend the standard (14 calendar days) or expedited (72-hour) service authorization timeframes up to an additional 14 calendar days if either the beneficiary requests the extension; or if the PIHP/CMHSP can show that there is a need for additional information and how the extension in the beneficiary's best interest.
   f. For service authorization not reached within the specified timeframes, on the date that the timeframe expired.

E. Reinstatement Or Continuation Of Medicaid Services
   1. PIHP/CMHSP must continue beneficiaries Medicaid services previously authorized while the local level appeal and/or State Fair Hearing are pending if:
      a. The beneficiary files the request for an Appeal timely within 60 calendar days from the date on the Adverse Benefit Determination Notice), **and**
      b. The beneficiary files the request for continuation of benefits timely, (on or before the latter of: within10 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 a previously authorized service; **and**
      d. The services were ordered by an authorized provider; **and**
      e. The period covered by the original authorization has not expired.
      f. The beneficiary's services were reduced, terminated, or suspended without an advanced notice, the PIHP/CMHSP 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 beneficiary withdraws the Appeal or request for State Fair Hearing; **or**
      b. The beneficiary fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP/CMHSP send the beneficiary notice of an adverse resolution to the beneficiary's appeal; **or**

c. A State Fair Hearing office issues a hearing decision adverse to the Medicaid beneficiary; **or**
d. The authorization expires or authorization service limits are met.

F. Payment Of Continued Or Reinstated Medicaid Services
1. If PIHP/CMHSP or State Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services and the beneficiary received the disputed services while the appeal was pending, PIHP/CMHSP or the State must pay for those services in accordance with State policy and regulations.
2. If the PIHP/CMHSP or the State Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal pending, the PIHP/CMHSP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary'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 Adverse Benefit Determination, the PIHP/CMHSP 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 beneficiary 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. PIHP/CMHSP shall comply with federal regulations providing a Medicaid beneficiary the right to an impartial review by a state level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:
   a. After receiving notice that the PIHP/CMHSP is upholding an Adverse Benefit Determination after Appeal.
   b. When the PHIP/CMHSP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals as described in 42 CFR 438.408.
2. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions are met:
   a. The review must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing.
   b. The review must be independent of both the State and the PIHP.
   c. The review must be offered without any cost to the enrollee.
   d. The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits.
3. PIHP/CMHSP shall not limit or interfere with the beneficiary's freedom to make a request for a State Fair Hearing.
4. Beneficiaries are given no more than 120 calendar days from the date of the applicable notice of resolution to file a request for a State Fair Hearing.
5. The PIHP/CMHSP 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 Medicaid beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP/CMHSP must reinstate services to the level before the Adverse Benefit Determination.
7. The parties to the State Fair Hearing include the PIHP/CMHSP, the beneficiary and his or her representative, or the representative of, a deceased beneficiary's estate.
8. A Recipients Right Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
9. Expedited hearings are available
10. Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:
    http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html
    OR Department of Licensing and Regulatory Affairs
    Michigan Office of Administrative Hearings and Rules
    State Fair Hearing
    http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

11. Southwest Michigan Behavioral Health (SWMBH) and its CMHSP will coordinate and/or conduct the Fair Hearing for Administrative Tribunal Hearings for Medicaid beneficiaries of the PIHP/CMHSP

H. Local Appeal Process
1. PIHP/CMHSP shall comply with federal regulations to provide a Medicaid beneficiary the right to a local level appeal of an Adverse Benefit Determination. The beneficiary, or representative of the beneficiary, may file an internal appeal under the following conditions:
   a. The beneficiary has 60 calendar days from the date of the Adverse Benefit Determination to request a local appeal.
   b. The Appeal can be requested orally or in writing. Oral inquires seeking to appeal an adverse benefit determination are treated as Appeals (to establish the earliest possible filing date for the Appeal.)
   c. In circumstances described under Section E: Reinstatement or Continuation of Medicaid Services, PHIP/CMHSPs will be required to continue/reinstate Medicaid Services while the appeal or state fair hearing is pending, until one of the events described in that section occurs.
   d. The Medicaid enrollee may file an appeal with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating local appeals.

2. When a Local Appeal is requested, PIHP/CMHSP must:
   a. Provide the beneficiary any 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 receipt a standard Appeal within five (5) business days and an

expedited Appeal within 72 hours of receipt.

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. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;
    ii. Who 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 beneficiary's condition or disease.
    iii. Who considers all comments, documents, records, and other information submitted by the beneficiary and/or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
e. PHIP/CMHSP must provide the beneficiary a reasonable opportunity to present evidence, testimony, allegations or law, in person or in writing. PHIP/CMHSP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals.
f. PHIP/CMHSP must provide the beneficiary and the beneficiary's representative the beneficiary's case file, including medical records and any other documents or records considered relied upon, or generated by or at the direction of the PIHP/CMPSP 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.
g. PHIP/CMHSP must provide opportunity to include, as parties to the appeal, the beneficiary's and beneficiary's representative or the legal representative of a deceased beneficiary's estate.
h. PHIP/CMHSP must provide the beneficiary with information regarding the right to a State Fair Hearing and the process to be used to request one. The beneficiary can request a State Fair Hearing only after receiving notice that SWMBH/CMHSP is upholding the Adverse Benefit Determination. In the case of SWMBH/CMHSP failing to adhere to the notice and timing requirements of 30 days, the beneficiary is deemed to have exhausted the PIHP's appeals process. The beneficiary may initiate a State fair hearing.

3. Notice of Resolution Requirements:
    a. PIHP/CMHSP must provide written notice of the resolution of the appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution.
    b. Beneficiary notice resolution must meet the requirements of 42 CFR 438.10(c)(1) that states "each PIHP entity must provide all required information in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," and meets the needs of those with limited English proficiency and/or limited reading
    c. The content of the notice of resolution must include the results of the appeal process and the date it was completed.

d. When the appeal is not resolved wholly in favor of the beneficiary, the notice of resolution must also include:
    i. The beneficiary's right to request a Medicaid State Fair Hearing and how to do so;
    ii. The beneficiary's right to request to receive benefits while the State Fair Hearing is pending and how to make that request; and
    iii. That the enrollee may, consistent with state policy, be held liable 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/CMHSP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed 30 calendar days from the day the PIHP/CMHSP receives the Appeal.
    b. *Expedited Appeal Resolution*: Each PIHP/CMHSP must establish and maintain an expedited review process for appeals when the PIHP/CMHSP determines (for a request from the beneficiary) or the provider indicates (in making a request on the beneficiary's behalf or supporting the beneficiary's request) that the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The PIHP/CMHSP may not take punitive action against a provider who requests an expedited resolution or supports the beneficiary's Appeal.
        i. If granted, the PIHP/CMHSP 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.
    c. If a request for expedited resolution of an appeal is denied the PHIP/CMHSP must:
        i. Transfer the appeal to the timeframe for standard resolution.
        ii. Make reasonable efforts to give the beneficiary prompt oral notice of the denial.
        iii. Within 2 calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a Grievance if they disagree with the decision.
        iv. Resolve the Appeal as expeditiously as the beneficiary's health condition requires but not to exceed 30 calendar days.
    d. The PIHP/CMHSP may extend the resolution and notice timeframe by up to 14 days if the beneficiary requests and extension, or if the PHIP/CMHSP shows to the satisfaction of the state (upon request) that there is a need for additional information and how the delay is in the beneficiary's interest. If the resolution timeframe is extended, not at the request of the beneficiary, the PHIP/CMHSP must complete all of the following:
        i. Make reasonable efforts to give the beneficiary prompt oral notice of the delay;
        ii. Within 2 calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the

right to file grievance if they disagree with the decision; and

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

I. Local Grievance Process

PIHP/CMHSP shall abide by federal regulations which provide beneficiaries the means of expression of dissatisfaction about any matter other than an Adverse Benefit Determinations. PIHP/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. Beneficiary Grievances
   a. Must be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of Grievances.
   b. May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her authorized representative.
   c. May be filed either orally or in writing.
2. For each Grievance filed by a beneficiary or PIHP/CMHSP must:
   a. Provide beneficiary any 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 capabilities.
   b. Acknowledge the receipt of the Grievance within 5 business days.
   c. Maintain record of Grievances for review by the PHIP Quality Management Team and/or the State as part of its quality strategy.
   d. Ensure that the individuals who make the decisions on the Grievance are Individuals:
      i. Who were neither involved in any previous level review or decision making, nor a subordinate of any such individual.
      ii. Who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues.
      iii. Who consider all comments, documents, records, and other information submitted by the beneficiary and/or the beneficiary's representative without regard to whether such information was submitted or considered previously.
   e. Provide the beneficiary with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The PHIP/CMHSP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 438.408(b) and (c) in the case of expedited resolution.
   f. Provide the beneficiary with written notice of resolution not to exceed 90 calendar days from the date the Grievance was received.
   g. The PHIP/CMHSP may extend the grievance resolution and notice timeframe by up to 14 calendar days if the beneficiary requests an extension or if the

PHIP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's best interest. If the resolution timeframe is extended not at the request of the beneficiary, the PHIP/CMHSP must complete all of the following:

i. Make reasonable efforts to give the beneficiary prompt oral notice of the delay;
ii. Within 2 calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file grievance if they disagree with the decision; and
iii. Resolve the grievance as expeditiously as the beneficiary's health condition requires and not later than the date the extension expires.

j. Beneficiary notice of Grievance resolution must meet the requirements 42 CFR 438.10(c)(1) that states "each PHIP/CMHSP must provide all required information in manner and format that may be easily understood and is readily accessible by beneficiaries and potential beneficiaries," and meets the need 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.

J. Appointment of an Authorized Representative
1. A Beneficiary 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 beneficiary, the beneficiary has the right to have a provider or authorized representative, acting on the beneficiary's behalf, file an Appeal or Grievance to the PHIP/CMHSP or request a State Fair Hearing.
3. In the event the beneficiary appoints a representative, the appeal or grievance must include:
   a. A Statement that the beneficiary 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 beneficiary'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 PHIP/CMHSP against a provider who acts on a consumer's behalf with the consumer's written consent to do so or who supports the consumer's grievance or appeal.
5. A provider may not charge a consumer for representation in filing 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 beneficiary, the 90-day timeframe begins on the date an authorized representative document is received by the PHIP/CMHSP. The PHIP/CMHSP must notify the beneficiary 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 limited to: Health Care Providers.

7. For expedited requests, PHIP/CMHSP will ensure that expedited requests are not inappropriately delayed due to missing documentation for appointment of a representative.
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 PHIP/CMHSP's request, PHIP/CMHSP must make and document, its reasonable efforts to secure the necessary documentation. PHIP/CMHSP will not undertake a review until or unless such documentation is obtained.

K. Record Keeping Requirements

1. PIHP/CMHSP is required to maintain records of beneficiary appeals, grievance and second opinions for review by State staff as part of the State quality strategy and the PIHP/CMHSP Memorandum of Understanding regarding service expectations and responsibilities.
   PIHP/CMHSP record of each Grievance, Appeal, Second Opinion must contain, at a minimum:
   a. General description of the reason for the Grievance, 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 Appeal, Grievance, or Second Opinion, if applicable.
   e. The date of the resolution for Appeal, Grievance, or Second Opinion.
   f. Name of the covered person for whom the Grievance, Appeal, or Second Opinion was filed.
2. PIHP/CMHSP must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.
3. Grievance and appeal records 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 PHIP 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 (PHIQAPI Plan) access, complaints and satisfaction will refer to both customer and client assessment when available.
   a. The PHIP QMC will review Grievance and Appeal member data at least annually, but usually quarterly to identify trends, or areas of improvements.

L. Reporting Requirements

1. PHIP/CMHSP shall maintain logs of any and all denials of services. PHIP/CMHSP shall adhere to applicable Grievance, Appeals and Second Opinion requirements of this policy.
2. CMHSP shall:

a. Maintain logs of all denials, appeals, and grievances of services and report Medicaid ones to the PHIP according to the PHIP/CMHSP Memorandum of Understanding.
b. Document all requests for Second Opinions. in the identified tracking system.

3. The PHIP shall:
   a. Monitor, track, and trend all Denials, State Fair Hearings, Grievance, Appeal, Second Opinion requests and dispositions.

M. Second Opinions

1. Medicaid and Non-Medicaid beneficiaries 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 initial PIHP/CMHSP service, at the time of the denial, the PIHP/CMHSP is required to provide the beneficiary 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 beneficiary 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 initial 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 appeal process timeframes, as outlined in of this policy for appeals, as the circumstances warrant.

3. Second Opinions are made available at no cost to beneficiaries, 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.
   a. This may be applied, but not limited to disputes regarding diagnoses, medications, and treatment modalities (such as therapeutic techniques).
   b. Second Opinions under 438.206 (b) may be requested at any time.

4 Second Opinion requests will be coordinated and documented by the customer service department of the PIHP/CMSHP.
   a. 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).

N. Mediation

j. 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.

k. 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.
   i. 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.

l. 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.

m. The PIHP/CMHSP or service provider involved in the dispute must participate in mediation if mediation is requested.

n. 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.

o. 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.

p. 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.

q. 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.

N. DIFS

1. PHIP/CMHSP will cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of the “Patient’s Right to Independent Review Act” (MCL 550.1901-1929).