NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: Five – Recipient Rights
PROCEDURE NAME: GRIEVANCE AND APPEAL PROCEDURE
EFFECTIVE DATE: August 1, 2022

PURPOSE

To establish a process for resolution of complaints over decisions regarding services and supports delivered by North Country Community Mental Health (NCCMH) in compliance with federal and state law, Michigan Department of Health and Human Services (MDHHS) contractual requirements and Northern Michigan Regional Entity (NMRE) protocols.

APPLICATION

North Country Community Mental Health provider operations.

DEFINITIONS

Adverse Benefit Determination: A decision that adversely impact's a recipient's claim for services due to:

1. Denial or limited authorization of a requested service, including the determination on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered service.
2. Reduction, suspension, or termination of a previously authorized service.
3. Denial, in whole or in part, of payment for a service.
4. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.
5. Failure to make an expedited authorization decision within 72 working hours from the date of receipt of a request for expedited service authorization.
6. Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning process.
7. Failure of NCCMH to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
8. Failure of NCCMH to resolve expedited appeals and provide notice with 72 working hours from the date of a request for an expedited appeal.
9. Failure of NCCMH to resolve grievance and provide notice within 90 calendar days of the date of request.
10. For a resident of a rural area with only one Managed Care Organization, the denial of the recipient request is to exercise their rights to obtain services outside the network.
11. Denial of recipients request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other financial responsibility.

Adequate Notice of Adverse Benefit Determination: Written statement to recipient to of the decision to deny or limit authorization of Medicaid covered services requested.

Advance Notice of Adverse Benefit Determination: Written statement to recipient to of the decision to reduce, suspend, terminate Medicaid services currently provided. Notice must be provided to the recipient at least 10 calendar days prior to the proposed date the action 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 continuing service delivery.

Client: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and or managed CMHSP.

Enrollee: A Medicaid beneficiary who is currently enrolled in Managed Care Organization, PIHP, Primary Care Case Manager or Primary Care Case Management in a managed care program.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by the Enrollee or the Enrollee's provider, when determined that waiting the standard appeal time would jeopardize life, physical or mental health, or ability to attain, maintain or regain maximum function. If the expedite review is requested , NCCMH determines if the request is warranted. If the Enrollee's provider makes the request or supports the recipient's request, NCCMH must grant the request.

Grievance: The Enrollee's expression of dissatisfaction about North Country Community Mental Health service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationship between a service provider and the client, failure to respect the client's rights regardless of whether remedial action is requested, or the client disputes extension of time proposed by NCCMH to make a service authorization decision.

Grievance Process: Impartial local level review of the Enrollee's grievance.

Grievance and Appeal System: The processes that NCCMH implements to handle Appeals of Adverse Benefit Determination and Grievance, as well as process to collect and track information about them.

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

Notice of Resolution: Written statement advising the Enrollee of a resolution to an Appeal or Grievance.

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

Service Authorization: The 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 authorized.

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing."

PROCEDURE

Notification of Grievance and Appeal Processes

Enrollee's must be given notice of the processes for resolving grievances and for appeal at the time of the request for services or in Advanced Benefit Determination whenever a Medicaid State Plan, waiver, or B3 is denied, reduced, suspended, or terminated. The notice must be in writing and must be provided in the language format needed by the individual to understand the content.

Action	Time Frame for Notice
Denial of service request ……...	14 calendar days
Plan of Service ……	At the time of the plan development
Reduction, suspension, or termination of service currently being received …….	10 calendar days before action or within the person-centered planning process
*Standard authorization decision that denies or limits services requested ……..	Within 14 calendar days of request (may be extended up to another 14 days at the request of the recipient or provider)
*Expedited authorization decision that denies or limits services requested.....	Within 72 hours
Unreasonable delay of start of services.....	At time of the action

Note: If a client's physician decides that a particular Medicaid State Plan or Waiver service is not medically necessary, no adverse action occurs.

*When a standard or expedited authorization of services decision is extended, NCCMH must give the recipient written notice of the reason for the decision to extend the timeframe and inform the recipient of the right to file an appeal if he or she disagrees with the decision.

At the initial Plan of Service (POS), when the POS is addended, and annually thereafter, applicants will be given a Notice of Hearing Rights that explains their options for appeal. An individual plan of service is developed through the person-centered process and describes those services that have been authorized to the recipient with the recipient's participation and agreement.

Denial of Access to CMHSP Services

1. If an applicant is denied access to services, an Advanced Benefit Determination is given. The applicant or their guardian or parent of a minor child, must be informed of their right to request a second opinion review of the Customer Services designee, and the request must be resolved within standard appeal time frames. Customer Services designee shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist. This staff person should not have been involved in the original decision to deny services. If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or developmental disability, or is experiencing an emergency or urgent situation, NCCMH shall direct services to the applicant.
2. If the applicant is Medicaid eligible, they may request a Fair Hearing before a State Administrative Law Judge in addition to the local grievance and appeals process. Non-Medicaid applicants must first access the local appeal process. After receiving a written response, the non-Medicaid applicant has 5 business days to request an Alternative Dispute Resolution Process from the Michigan Department of Health and Human Services. MDHHS shall complete the review within 30 business days of receipt and notify the applicant or guardian/parent in writing.
3. An applicant may not file a recipient rights complaint, as they do not have standing as a recipient. They may file a rights complaint if the request for a second opinion is denied.

Denial of Hospitalization

1. If the pre-admission screening or children's diagnostic and treatment service unit denies hospitalization, an Adequate Notice of Adverse Benefit Determination should be given. The applicant or their guardian or their parent in the case of a minor child, may request a second opinion from the Customer Services designee who shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be resolved in 3 days, excluding Sundays and Holidays, after receiving the request. If the conclusion of the second opinion is different from the conclusion of the preadmission screening unit or children's diagnostic and treatment service unit, the Chief Clinical Officer, in conjunction with the Medical Director, shall decide based on all clinical information available. The decision shall be confirmed in writing to the individual who requested the second opinion, and the confirming document shall include the signatures of the Chief Clinical Officer 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 or children's diagnostic and treatment service unit shall provide appropriate referral services.
2. If the initial request for inpatient admission is denied and the individual is a current recipient of other NCCMH services, the individual or someone on their behalf may file a Chapter 7 complaint alleging a violation of their right to treatment suited to condition.
3. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current recipient of other NCCMH services and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on their behalf may file a complaint with the NCCMH Rights Office for processing under Chapter 7A.
4. The applicant may appeal the decision utilizing the Local Appeal process.
5. The applicant (Medicaid or non-Medicaid) may request an Expedited Local Appeal if waiting the standard 30 days would jeopardize life, health, or ability to attain, maintain or regain maximum function.
6. Medicaid recipients may request a Fair Hearing on actions that impact Medicaid covered services within 120 days of denial. For non-Medicaid covered services, the MDHHS Alternative Dispute Resolution process may be accessed and must be filed within 5 days from the date of the local appeal decision.

Suspension, Reduction or Termination of Existing Services

1. Whenever an existing service or support is to be suspended, terminated or reduced outside of the treatment planning meeting(s), the individual will be informed in writing at least 10 calendar days prior to the effective date of the Adverse Benefits Determination. In addition, the requesting provider must also be provided notice of any decision by the CMHSP to deny a service request or authorize a service in an amount, scope, or duration less than requested. Notice to the provider does NOT have to be in writing. The Advanced Benefit Determination notice shall include:

    a. The Enrollee notice must be in writing and must meet the requirements of (i.e., 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 proficiency).
    b. 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.
    c. Description of Adverse Benefit Determination.
    d. The reason(s) for the Adverse Benefit Determination
    e. 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).

f. Notification of the Enrollee's right to request an Appeal, including information on exhausting the Appeals process, and the right to request a State Fair Hearing thereafter.
g. Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal.
h. Notification of the Enrollee's right to have 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").
i. Description of the procedures that the Enrollee is required to follow to exercise any of these rights.
j. An explanation that the Enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.

2. Exceptions to Advanced Benefit Determination notification rule includes:

a. It has information confirming death of the client.
b. The client or their legal representative has provided a written statement that they no longer wish to have services or gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying the information.
c. The Enrollee has been admitted to an institution where they are ineligible under Medicaid for further services.
d. The Enrollee's whereabouts are unknown, and the post office returns mail directed with no forwarding address.
e. It establishes the fact that the recipient 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 recipient's physician.
g. The date of the action will occur less than 10 calendar days.
h. NCCMH may shorten the period of Advanced Benefit Determination to 5 days before the date of action if it has facts indicating that the action should be taken because of probable fraud and these facts have been verified, if possible, through secondary sources.

3. Maintaining Medicaid-covered services and supports:

a. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the CMHSP MUST continue the Enrollee's benefits if all the following occur:

    1. The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice);
    2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i.) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii.) the intended effective date of the proposed Adverse Benefit Determination).
    3. The period covered by the original authorization has not expired.

If NCCMH's action is upheld by appeal of State Fair Hearing Decision, NCCMH may seek reimbursement from the recipient for the cost of any services provided the

recipient during this period of time, up to the individual's ability to pay as determined by the Code.

4. Reinstatement of Medicaid Covered Services:

   a. NCCMH must reinstate Medicaid covered services if a Enrollee or their legal representative requests a State Fair Hearing not more than 10 calendar days after the date of the action.
   b. The reinstated Medicaid covered services must continue until the hearing decision unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.
   c. 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.

   If NCCMH reinstates and continue Medicaid covered services, they will continue until the following occurs:

   a. The Enrollee withdraws the Appeal or request for State Fair Hearing;
   b. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal
   c. A State Fair Hearing office issues a decision adverse to the Enrollee.

State Fair Hearing Appeal Process

Federal regulations provide a Medicaid Enrollee the right to appeal determination through an internal review. The CMHSP is the first level of appeal, also known as local appeal. The Enrollee also has a right to a State-level fair hearing with an Administrative Law Judge, of an action made by NCCMH.

1. An Enrollee has the right to request a fair hearing when NCCMH fails to adhere to the Advanced Benefit Determination timelines.
2. The State may offer or arrange for an external medical review in connection with State Fair Hearing, if certain conditions are met.
3. NCCMH may not limit or interfere with the recipient's freedom to make a request for a fair hearing.
4. Recipients are given 120 calendar days from the date of the Advanced Benefit Determination to file a request for a State fair hearing.
5. If the recipient or representative requests a fair hearing within 10 calendar days from the date of the Advanced Benefit Determination, NCCMH must reinstate the Medicaid services as durations described above.
6. If the recipient's services were reduced, terminated, or suspended without advance notice, NCCMH must reinstate services to the level before the Adverse Benefit Determination.
7. The parties to the State fair hearing include NCCMH, the Enrollee and their representative, or the representative of a deceased Enrollee's estate.
8. Expedited hearings are available.

Local Appeal Process

Responsibility for when Enrollee request an appeal are as follows:

1. Customer Services designee with give reasonable assistance in completing forms and taking other steps to complete the appeals process. This assistance includes, but is not

limited to, auxiliary aids and services, and toll-free numbers with TTY/TDD and interpreter services.

2. Acknowledge receipt of the appeal.
3. Maintain a log of all requests for appeals to allow reporting to the NCCMH Quality and Utilization program.
4. Ensure that the individuals who make the decisions on appeal were not involved in previous decision making.
5. When deciding an appeal that involves either 1) clinical issues or 2) denial based on lack of medical necessity, the individual should of appropriate clinical expertise as determined by the state.
6. Provide Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person and in writing within the resolution timeframe.
7. Give Enrollee, and or his representative, before or after the appeal process, to examine the clinical record and any other documents considered during the appeal process.
8. Allow parties in the appeal process to include the recipient and their representative or the legal representative of a deceased client's estate.

Appeal Process:

1. Enrollee may request an appeal either orally or in writing. Unless the Enrollee requests an expedited resolution, and oral request for Appeal must be followed by a written, signed request with 60 days of Advanced Benefits Determination.
2. The Customer Services Designee will:

    a. Log receipt of the appeal and acknowledge receipt to the recipient within 2 calendar days.
    b. For Medicaid recipient disputing an action that impacts a Medicaid covered service, advise the individual, guardian, or in the case of a minor, the parent, that they must exhaust the local appeal process. If they receive notification that the decision is upheld, they may file for a State Fair Hearing. Customer services designee will provide information which shall include the process for filing the request for a hearing, an offer of assistance in filing the request and an explanation of time frames and circumstances under which Medicaid services will be continued pending the hearing decision.
    c. Facilitate resolution of the appeal within 30 calendar days of receipt of the appeal. Ensure an expedited review of an appeal involving an emergent situation where the standard appeal timeframe would seriously jeopardize the health or life of the individual. Such a review shall be completed within 72 hours of receipt of the appeal.
    d. Send the notice of disposition to the appellant containing an explanation of the results of the resolution and the date it was completed within 2 days of completion.
    e. If a request for expedited resolution of an appeal is denied, reasonable effort will be made to give recipient prompt oral notice of the denial with follow-up written notice within 2 calendar days.

Grievance Process

1. The client, guardian or parent of a minor child may file a grievance orally, in writing, or in person, at any time regarding dissatisfaction with any aspect of service provision other than an Advanced Benefit Determination as defined in this procedure or an allegation of a recipient rights violation. The recipient will be given reasonable assistance in completing the Grievance form. This includes, but is not limited to, auxiliary aids and services upon request, such as providing toll-free numbers that have adequate TTY/TDD and interpreter capability. The grievance will be filed with the NCCMH Customer Services unit.

2. Customer Services will:

    a. Maintain record of Grievances for review by the Quality Improvement Committee.
    b. Determine whether the grievance is more appropriately a rights complaint and, if so, refer the grievance, with the Enrollee's permission, to the Office of Recipient Rights.
    c. Acknowledge receipt of the grievance to the recipient in writing within 2 days.
    d. Submit the written grievance to the appropriate staff, including an NCCMH administrator with the authority to require corrective action.
    e. For grievances regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the recipient's condition or disease.
    f. Facilitate resolution of the grievance as expeditiously as the recipient's health condition requires but no later than 90 days. NCCMH may extend the resolution time by 14 days of the Enroll requests an extension or if NCCMH can show the state that there is a need for additional information.
    g. Medicaid grievances may access the State Fair Hearings process if NCCMH fails to respond to the grievance within 90 calendar days. This constitutes an Adverse Benefits Determinations and can be appealed to the Administrative Hearings systems.
    h. A written notification of the outcome will be provided to the client, guardian, or parent of a minor child within 2 calendar days of a decision. The notice shall include the results of the grievance process, the date the grievance process was concluded, the right to request a fair hearing as stated above and the process to access the fair hearing.
    i. There is no time limit to file a grievance.

<u>MDHHS Alternative Dispute Resolution Process</u>

1. If a non-Medicaid client is dissatisfied with the Appeal Process resolution, they can pursue a resolution through the MDHHS Alternative Dispute Resolution Process within ten calendar days of receipt of the decision of Appeal Process or upon NCCMH's failure to meet standard or expedited appeal notice of resolution timeframes.

    a. Access to the MDHHS process does not require agreement by both parties but may be initiated solely by the client.
    b. The individual has 10 calendar days from the written notice of the NCCMH dispute resolution process outcome to request access to the MDHHS Alternative Dispute Resolution Process.
    c. NCCMH shall also offer to assist the individual in filing a dispute with MDHHS.
    d. MDHHS will accept a written request for a review, however, the request must include the following information and NCCMH shall also include the items listed here in communications with MDHHS.

        1. Name of the Enrollee.
        2. Name of guardian legally empowered to make treatment decisions, or parent of a minor.
        3. Daytime telephone number where the recipient/applicant, guardian legally empowered to make treatment decisions or parent of a minor child may be reached.
        4. Name of community mental health agency where services were denied.
        5. Client's description of the adverse impact on the recipient/applicant associated with the denial, suspension, reduction, or termination of services.

e. Written requests should be directed to:

Michigan Department of Health and Human Services
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for MDHHS Level Dispute Resolution

Lewis Cass Building –5th Floor
Lansing, MI 48913

f. MDHHS shall review all requests within two business days of receipt.

g. In the event that the MDHHS representative believes that the denial, suspension, termination or reduction of services and/or supports will pose an immediate and adverse impact upon the individual's health and/or safety, the issue will be referred within 1 business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS/CMHSP contract.

h. In all other cases, the MDHHS representative shall attempt to resolve the issue with the client and the CMHSP within 15 business days. The recommendations of the MDHHS representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the client. If MDHHS agrees with the CMHSP the client may be required to pay for the extended services. Written notice of the resolution shall be submitted to the client, their guardian, or parent of a minor client.

Monitoring and Quality Assurance

Quarterly reports of grievances and appeals will be reported to the Risk Management Committee and to the PIHP Customer Services department. Grievance and appeal records will be available to MDHHS for review upon request. An Annual Report will be given to the governing Board.

NCCMH FORMS: Adequate Notice of Hearing Rights; NCCMH Action Notice (Termination, Suspension, Reduction); Request for Second Opinion; Request for Local Appeal; Grievance

REFERENCE: 42 CFR 431.200-250; 42 CFR 438.400;
MDHHS PIHP Specialty Services Contract;
Northern Michigan Regional Entity Grievance and Appeal, Fair Hearing Protocol;
MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY20 Attachment C6.3.2.1;
Michigan Mental Health Code, Chapter 7 and Chapter 4;
Balanced Budget Act of 1997

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APPROVED BY SIGNATURE

Amy Christie — *August 3, 2022*
Chief Quality Officer — Date

Brian Babbitt — *August 2, 2022*
Chief Operating Officer — Date