ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 11/23

CHAPTER Access to Services		**CHAPTER** 02	**SECTION** 001	**SUBJECT** 0040
SECTION Access	**SUBJECT** Grievance Process			
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I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & Subcontractors
- ☒ Direct-Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure that all individuals have the right to a fair and efficient process for resolving disagreements regarding their services and supports. An individual receiving or applying for public mental health services may access several options to pursue the resolution of disagreements. This system includes both mental health and substance use disorder services and treatments. It is the administrative procedures of SCCCMHA to follow all state and federal regulations regarding the resolution of complaints and disputes individuals may have about their services and supports.

This administrative procedure and any corresponding policies in no way requires the individual to utilize the mediation, grievance or appeal processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and SCCCMHA policies/administrative procedures relative to the filing of Recipient Rights Complaints. This is also true for the Recipient Rights process for substance use disorder services.

III. DEFINITIONS:

A. Adverse Benefit Determination: A decision that adversely impacts an individual's claim for services due to:

1. 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.
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 with 14 calendar days from the date of receipt of a standard request for service.

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5. Failure to make an expedited authorization decision within 72 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 and as authorized by the SCCCMHA.
7. Failure of PIHP/SCCCMHA to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
8. Failure of PIHP/SCCCMHA to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.
9. Failure of SCCCMHA to resolve grievance and provide notice within 90 calendar days of the date of the request.
10. For residents of a rural area with only one provider, the denial of an enrollee's request to exercise his/her right to obtain services outside the network.
11. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibilities.

B. Adequate Notice of Adverse Benefit Determination: Written statement advising the enrollee of a decision to deny or limit the authorization of Medicaid services requested. Notice must be provided to the Medicaid enrollee **on the same date the Adverse Benefit Determination takes effect.**

C. Advance Notice of Adverse Benefit Determination: Written statement advising the enrollee of a decision to reduce, terminate, or suspend Medicaid services currently provided. Notice must be provided to the enrollee **at least 10 calendar days prior the proposed date the Adverse Benefit Determination is take effect.**

D. Complaint: A formal concern or inquiry raised by a person served, about the SCCCMHA provider that requires a response and follow up.

E. Grievance: Enrollee's expression of dissatisfaction about SCCCMHA services issues, **other than an Adverse Benefit Determination.** Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the enrollee, failure to respect the enrollee's rights regardless of whether remedial action is requested, or the right to dispute an extension of time proposed by the SCCCMHA to make an authorized decision.

F. Grievance Process: Impartial local review of an enrollee's grievance about SCCMHA service-related issues.

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

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

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I. Recipient Rights Complaint: Written or verbal statement by a person receiving services, or anyone acting on behalf of the person receiving services, 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.

IV. STANDARDS:

A. GENERAL

1. Individuals receiving publicly funded services may access several options to pursue the resolution of complaints. These options may include the right to file a local appeal, grievance or a Recipient Rights complaint. Options may also include the right to request mediation, request a second opinion or a State Fair Hearing.

2. During the initial contact with Access Center and the Central Intake Unit, the applicant is provided information both verbally and in writing of his/her rights, mediation, the grievance process, and the right to access the appropriate process. (Recipient Right process is not available to applicant.)

3. Individuals who wish to file a complaint may do so independently or with the assistance of Customer Services, other available staff, or a person of their choosing. A provider may not refuse to assist the individual who needs help filing a complaint and submitting that complaint for resolution.

4. Should an individual involved with this process have limited-English proficiency, the CMHSP/organizational providers will take necessary and reasonable steps to make any accommodations. This includes, but is not limited to, auxiliary aids and services such as interpreter services, toll free numbers, TTY/TTD, and/or Video Relay Services, all at no cost to the individual.

5. SCCCMHA provides information about the grievance system to all providers and subcontractors at the time they enter into a contract. The information includes the enrollees right to file grievances; the requirements and timeframes for filing; and the availability of assistance in the filing process. Information on mediation will also be provided.

B. MEDIATION

1. A recipient/recipient's representative may request mediation at any time when there is a dispute related to service planning or the services/supports provided by a CMHSP or services/supports provided by a CMHSP contracted provider. Disputes around services defined in Chapter 2, 330.1206 are open to mediation.

2. A recipient/recipient's representative has the right to request mediation at the same time a local dispute resolution, local appeal, Medicaid Fair hearing process or recipient rights complaint investigation is occurring.

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3. A recipient/recipient's representative has the right to request and have other dispute resolution processes suspended unless prohibited by law or precluded by a report of an apparent or suspected violation of rights as delineated in Chapter 7 of the Mental Health Code.

4. Mediation services are provided by a neutral third party contracted through and paid for by the Michigan Department of Health and Human Services.

5. Mediation does not apply to:

   a. Disputes regarding medical necessity determinations.

   b. An Assisted Outpatient Treatment (AOT) court order once granted by a probate judge.

   c. Recipient rights services or to any disputes regarding recipient rights services.

C. GRIEVANCE

1. Medicaid grievances must be resolved within 90 calendar days of the date of the request/complaint. The 90 day time period may be extended up to 14 calendar days should the individual/representative request the extension, or if the SCCCMHA justifies the need for additional information and documents how the delay is in the interest of the individual. If an extension is granted, the SCCCMHA must complete all of the following: Make reasonable efforts to give the individual prompt oral notice of the delay; within 2 calendar days give the individual written notice of the reason for the decision to extend the timeframe and inform the individual of the right to file a grievance if they disagree with the decision; resolve the grievance as expeditiously as the individual's health condition requires and not later than the date of the extension expires.

2. A grievance may be filed at any time; there is no time limit.

3. A grievance may be filed by the enrollee, guardian, parent of minor child or legal representative, or provided with written permission from the individual indicating the wish to file a grievance. 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.

4. The enrollee has the right to concurrently file an appeal of Adverse Benefit Determination and a grievance regarding other service complaints.

5. A grievance may be filed orally or in writing.

6. All steps taken to resolve grievances must be documented in the "Grievance Module" of electronic health record, which will generate the appropriate letters containing the required information. For grievances resolved within three (3) business days, a combination "Acknowledgement – Resolution" letter may be sent to the individual. Notes shall include the name, title and organization of any persons contacted regarding the grievance. For all

grievances concerning either clinical issues or denial of an expedited resolution of an Appeal the grievance module notes shall include the name, title and credentials of the decision maker. Any missing information and/or additional details from the Provider or the individual shall be requested as soon as possible. Requests for additional information may be made by phone, fax, secure email, EHR messaging system or via letter. After two (2) unsuccessful attempts to contact the individual/representative to obtain additional information, the staff shall continue to process the grievance and resolve the matter without additional information whenever possible. All pertinent documentation relating to resolving the grievance shall be uploaded as an attachment in the EHR grievance module.

7. The PIHP **has delegated** the processing (acknowledgement, investigation, and resolution) of **mental health** service related grievances to SCCCMHA as defined in contract language.

8. The PIHP **has not delegated** the processing (acknowledgement, investigation, and resolution) of **substance use disorder** services related grievances and shall remain responsible for this activity.

9. The SCCCMHA designated Grievance Manager is the Assistant Division Director. This individual shall meet the following criteria:

    a. Shall not have been involved in any previous level review or decision-making nor a subordinate of any such individual.

    b. When the Grievance involves either clinical issues or denial of expedited resolution of an Appeal, the Grievance Manager shall have appropriate clinical expertise in treating the beneficiary's condition or disease.

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

    d. Shall have the authority to require corrective action, if needed.

10. The SCCCMHA designated individual to oversee administrative function of grievances is the Chief Operating Officer. The role of this individual is to receive the grievance and initial complaint information, provide to the Assistant Division Director for processing, ensure grievance information is documented within the electronic health record, and provide monthly grievance reporting to the PIHP.

<u>Grievance timeframes for non-Medicaid individuals</u>

11. Federal regulations provide Medicaid enrollees with the right to a local grievance process for issues that are not Adverse Benefit Determination and the CMH is extending this right to non-Medicaid individuals. Non-Medicaid Grievances follow a formal process:

    a. The individual is informed how to submit a grievance and identify who is responsible for

facilitating resolution of the grievance. For non-Medicaid individuals a grievance must be initiated within 30 days from the time Notice of Adverse Benefit Determination received.

b. The SCCCMHA must provide resolution to the non-Medicaid grievance within 60 calendar days (this is the timeline for non-Medicaid grievances only).

c. If the non-Medicaid individual is not happy with the outcome of the grievance, they have the right to access the MDHHS Alternative Dispute Resolution process.

D. STATE FAIR HEARING

1. A State Fair Hearing is allowed if SCCCMHA fails to adhere to the notice and timing requirement for the resolution of grievances (90 days).

2. The SCCCMHA may not limit or interfere with an enrollee's freedom to make a request for a State Fair Hearing.

3. The parties to the State Fair Hearing include the PIHP, the enrollee and his/her representative. The SCCCMHA is not a party to the State Fair Hearing and is not responsible to facilitate this process.

E. RECORD KEEPING

1. SCCCMHA is required to keep records of the Medicaid and non-Medicaid mental health grievances that are processed. The PIHP will review the CMH grievances to ensure compliance with requirements, and as part of the state quality strategy.

2. Records must contain the minimum:

a. A general description of the reason for the grievance.

b. The date received.

c. The date of review.

d. The resolution at each level of the grievance, if applicable.

e. The date of the resolution at each level, if applicable.

f. The name of the covered individual for whom the grievance was filed.

V. PROCEDURES:

Individual Receiving/Applying for Services

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1. Files a grievance orally or in writing to SCCCMHA for mental health related complaints or to the PIHP for SUD service related complaints. May request mediation in lieu of other dispute resolution processes or in tandem with those processes.

PIHP/SCCCMHA Staff

2. Receives a complaint and determines if it is a request for mediation, a grievance, an appeal, or a Recipient Rights complaint, and refers to the appropriate office of jurisdiction for processing.

3. Contacts and shares the complaint information with the SCCCMHA Chief Operating Officer if the complaint is request for mediation or a grievance. Recipient rights concerns are shared with the CMHSP Recipient Rights Office.

SCCCMHA Chief Operating Officer

4. Reviews requests for mediation and contacts the mediation center in mediation matters.

5. Reviews grievance information and conveys grievance information to the appropriate SCCCMHA Assistant Division Director for processing.

SCCCMHA Assistant Division Director

6. Acknowledges the grievance in writing within five (5) business days, including a notification to the recipient/recipient's representative of the right to request mediation.

7. Completes an investigation by taking the steps necessary to gather information to create the best resolution.

    a. Designated staff shall:

        (1) Acknowledge and log each grievance received.

        (2) Ensure the individual(s) who make decisions of grievances are individuals:

            i. Who were not involved in the original complaint or any previous level of review or decision making.
            ii. Are healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the individual's condition or disease.
            iii. Have the authority to require corrective action if necessary.
            iv. Shall take into account all comments, documents, records and other information submitted by the individual/representative without regard to whether such information was submitted or considered in the initial complaint.

8. Provides a written Notice of Resolution of the grievance to the individual/representative within 90 calendar days for Medicaid grievances (and within 60 calendar days for non-Medicaid). Notice of Resolution must meet the requirements of 42 CFR 438.10.

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a. Grievances shall not be closed in the grievance module until full resolution. This includes contacting the individual/representative to discuss his/her satisfaction with the proposed resolution. After two (2) documented unsuccessful attempts to contact the individual/representative to discuss the resolution, a resolution letter may be sent.
b. Grievances which include a change in provider should not be closed or considered resolved until the new service provider assumes the case and appointments have been scheduled and verified.
c. Notice of Resolution shall meet the requirements of 42 CFR 438.10 (i.e., presented in a manner and format that may be easily understood and meets the needs of those with limited English proficiency and/or limited reading proficiency).
d. Notice of Resolution shall contain:

(1) Statement of the complaint.

(2) Substance/reason for the complaint.

(3) Action(s) taken to resolve the grievance.

(4) Results of the grievance process.

(5) Date the grievance process was concluded.

e. Notice of the Medicaid individual'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; if resolution of the grievance exceeded 90 day timeframe, a notice of Adverse Benefit Determination needs to be generated and sent with the resolution letter. This must include the state fair hearing request form and envelope. For non-Medicaid grievances, the Notice of Resolution must include the rights of the non-Medicaid individual to access the MDHHS Alternative Dispute Resolution process if they are not happy with the outcome of the grievance.

9. Logs all grievances and information into the electronic health record.

SCCCMHA Chief Operating Officer

10. Submits quarterly grievance reports to the PIHP as required per contract.

VI. REFERENCES:

A. PIHP/CMH contract, Appeal and Grievance Resolution Processes Technical Requirement

B. MDHHS/CMH contract, CMHSP Local Dispute Resolution Process, Attachment C.6.3.2.1.

C. Region 10 PIHP policy 07-02-01 Grievance and Appeal System

D. 42 CFR 438 et all

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E. PIHP/CMH contract, Mediation in Mental Health Dispute Resolution Technical Requirement

VI. EXHIBITS:

None available.

VIII. REVISION HISTORY:

Dates issued 05/14, 05/15, 09/16, 09/17, 04/18, 05/19, 11/20, 11/21, 11/22.