COPPER COUNTRY MENTAL HEALTH SERVICES BOARD

POLICY AND PROCEDURE

DATE: August 29, 2018 Grievance & Appeals-Medicaid P9

RESCINDS: April 27, 2016

CATEGORY: Recipient Rights

SUBJECT: Grievance & Appeal Processes - Medicaid and Healthy Michigan (HM)

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS), hereafter referred to as Community Mental Health Services Provider (CMHSP), that all recipients have the right to a fair and efficient process for resolving disputes regarding their services and supports managed and/or delivered by CMHSP and its provider network. A recipient of, or applicant for, public mental health services have various avenues available to pursue the resolution of disputes. Recipients will receive notice of their rights, information about the grievance and appeal process, and be assisted, as necessary or requested, in achieving resolution of service delivery disputes.

PURPOSE: The purpose of this policy is to outline the grievance and appeals processes for Medicaid recipients, **including Healthy Michigan recipients**, of CMHSP or through its provider network, in order to promote the resolution of recipient concerns, and support and enhance the overall goal of improving the quality of care.

I. DEFINITIONS

The following terms and definitions are utilized in this policy.

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

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- 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 Service Authorization decision and

provide notice about the decision within **14 calendar days** from the date of 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 the CMHSP.
- Failure of the CMHSP to resolve standard Appeals and provide notice within **30 calendar days** from the date of a request fora standard appeal.
- Failure of the CMHSP to resolve expedited Appeals and provide notice within **72 hours** from the date of a request for an expedited appeal.
- Failure of the CMHSP to resolve Grievances and provide notice within **90 calendar days** of the date of the request.

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

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

Appeal: A review at the local level by a CMHSP of an Adverse Benefit Determination, as defined above, presided over by individuals not involved in the decision-making or previous level of review.

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

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by a recipient or the recipient's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the recipient requests the expedited review, the CMHSP determines if the request is warranted. If the recipient's provider makes the request, or supports the recipient's request, the CMHSP must grant the request.

Grievance: Recipient's expression of dissatisfaction about CMHSP

service 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 recipient, failure to respect the recipient's rights regardless of whether remedial action is requested, or a recipient's dispute regarding an extension of time proposed by the CMHSP to make a service authorized decision.

Grievance Process: Impartial local level review of a recipient's Grievance.

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

Hearings Coordinator: CMHSP staff or his/her designee appointed by the Executive Director to coordinate the Administrative Hearing process.

Medicaid Services: Services provided to a recipient 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 CMHSP of the resolution of a Grievance or Appeal.

Recipient: A person who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through CCMHS or a provider that is under contract with CCMHS.

Recipient Rights Complaint: Written or verbal statement by a recipient, or anyone acting on behalf of the recipient, 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.

Service Authorization: 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, as required under applicable law.

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

II. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation requires the State to ensure through its contracts with PIHPs/CMHSPs, that each CMHSP has a Grievance and Appeal system in place for recipients.

The Grievance and Appeal System must provide recipients:

- An Appeal process (one level, only) which enables recipients to challenge Adverse Benefit Determinations made by the CMHSP or its agents.
- A Grievance Process.
- The right to **concurrently** file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- 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 CMHSP level Appeal.
- Information that if the CMHSP fails to adhere to notice and timing requirements as outlined in CMHSP Appeal Process, the recipient is deemed to have exhausted the CMHSP's Appeals process. The recipient may initiate a State Fair Hearing.
- The right to request, and have, Medicaid covered benefits continued while a local CMHSP Appeal or State Fair Hearing is pending.
- With the written consent from the recipient, the right to have a provider or other authorized representative, acting on the recipient's behalf, file an Appeal or Grievance to the CMHSP, or request a State Fair Hearing. The provider may file an Appeal or Grievance or request a State Fair Hearing on behalf of the recipient since the State permits the provider to act as the recipient's authorized representative in doing so. Punitive action may not be taken by the CMHSP against a provider who acts on the recipient’s behalf with the recipient’s written consent to do so.

III. NOTICE OF ADVERSE BENEFIT DETERMINATION

A CMHSP is required to provide timely and “adequate” notice of any Adverse Benefit Determination.

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements:

1. Recipient notice must be in writing, in a “…manner and format that may be easily understood and is readily accessible by such recipients and potential recipients,” and meet the needs of those with limited English proficiency and or limited reading proficiency;

2. Notification that 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;

3. Description of Adverse Benefit Determination;

4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;

5. Notification of the right of the recipient to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the recipient's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the recipient's right to request an Appeal, including information on exhausting the CMHSP's single local appeal process, and the right to request a State Fair Hearing thereafter;

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

8. Notification of the recipient'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 recipient may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the recipient is required to follow in order to exercise any of these rights; and

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

B. Timing of Notice:

1. Adequate Notice of Adverse Benefit Determination:

a. For a denial of payment for services requested (not currently provided), notice must be provided to the recipient at the time of the Adverse Benefit Determination affecting the claim.

b. For a Service Authorization decision that denies or limits services, notice must be provided to the recipient within **14-days** following receipt of the

request for service for standard authorization decisions, or within **72-hours** after receipt of a request for an expedited authorization decision.

c. For Service Authorization decisions not reached within **14-days** for standard request, or **72-hours** for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

- NOTE, however, that the CMHSP may be able to extend the standard Service Authorization timeframe in certain circumstances. If so, the CMHSP must: (i) provide the recipient written notice of the reason for the decision to extend the timeframe and inform the recipient of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the recipient's health condition requires and no later than the date the extension expires.

2. Advance Notice of Adverse Benefit Determination:

a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.

b. Must be provided to the recipient at least **10 calendar days** prior to the proposed effective date.

c. Limited Exceptions: The CMHSP may mail an adequate notice of Adverse Benefit Determination, not later than the date of the Adverse Benefit Determination to terminate, suspend or reduce previously authorized services, IF:

i. The CMHSP has factual information confirming the death of a recipient;

ii. The CMHSP receives a clear written statement signed by a recipient that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the recipient understands that this must be the result of supplying that information;

iii. The recipient has been admitted to an institution where he is ineligible under the plan for further services;

iv. The recipient's whereabouts are unknown, and the post office returns agency mail directed to him indicating no forwarding address;

v. The CMHSP establishes that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

vi. A change in the level of medical care is prescribed by the recipient's physician;

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements;

viii. The date of the Adverse Benefit Determination will occur **in less than 10 calendar days.**

ix. The CMHSP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the recipient (in this case, the CMHSP may **shorten** the period of advance notice **to 5 days before** the date of the Adverse Benefit Determination).

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The recipient must be provided written notice.

2. The requesting provider must be provided notice of any decision by the 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.

3. 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 Adverse Benefit Determination, and requires a written notice of Adverse Benefit Determination.

IV. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

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 recipient's benefits if all the following occur:

1. The recipient files the request for Appeal timely (within **60**

calendar days from the date on the Adverse Benefit Determination Notice);

2. The recipient 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) and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits:
If the CMHSP continues or reinstates the recipient's benefits, at the recipient's request, while the Appeal or State Fair Hearing is pending, the CMHSP must continue the benefits until one of following occurs:

1. The recipient withdraws the Appeal or request for State Fair Hearing;

2. The recipient fails to request a State Fair Hearing and continuation of benefits within **10 calendar days** after CMHSP sends the recipient notice of an adverse resolution to the recipient's Appeal;

3. A State Fair Hearing office issues a decision adverse to the recipient.

C. If the final resolution of the Appeal or State Fair Hearing upholds the CMHSP's Adverse Benefit Determination, the CMHSP may, consistent with the State's usual policy on recoveries and as specified in the CMHSP's contract, recover the cost of services furnished to the recipient while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements.

D. If the recipient's services were reduced, terminated or suspended without an advance notice, the CMHSP must reinstate services to the level before the action.

E. If the CMHSP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the recipient received the disputed services while the Appeal was pending, the CMHSP or the State must pay for those services in accordance with State policy and regulations.

F. If the CMHSP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMHSP must authorize or provide the disputed services promptly, and as

expeditiously as the recipient's health condition requires, but no later than **72 hours** from the date it receives notice reversing the determination.

V. SERVICE DISPUTE OPTIONS PROCESSES

When a Medicaid recipient disagrees with a Service Authorization decision or their services are not provided within the required timeframe, the Medicaid recipient may Appeal that decision or delay using various avenues of dispute processes; however, must exhaust the local dispute processes before they may request a State Fair Hearing. A Medicaid recipient may use the following processes to Appeal a Service Authorization decision or delay of services.

A. Denial of Hospitalization

1. Request for Second Opinion

a. If a preadmission screening unit or children's diagnostic and treatment service of a CMHSP denies hospitalization, the recipient, his/her guardian or his/her parent in the case of a minor child, may request a Second Opinion from the Executive Director of the CMHSP.

b. 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 determination of the second opinion is different from the determination of the preadmission screening unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based on all clinical information available within **1 business day.**

c. The Executive Director's decision shall be confirmed in writing to the recipient 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.

d. If a recipient is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide appropriate referral services.

2. Rights Complaint

a. If the request for a Second Opinion is denied, the recipient or someone on his/her behalf may file a recipient rights complaint with the recipient Rights Office of CMHSP.

b. If the initial request for inpatient admission is denied and the recipient is a current recipient of other CMHSP services, the recipient or someone on his/her behalf is informed that they may file a Recipient Rights Complaint with the Recipient Rights Office alleging a violation of his/her right to treatment suited to condition.

c. If the Second Opinion determines the recipient is not clinically suited for hospitalization and the recipient is a current recipient of other CMHSP services, and a recipient rights complaint has not been filed previously on behalf of the recipient, the recipient or someone on his/her behalf may file a complaint with the Recipient Rights Office of CMHSP.

3. Local Appeal

See Local Appeal Process section.

4. State Level

See State Fair Hearing Appeal Process section.

B. Denial of Access to Community Mental Health Program Services

If an initial applicant for CMHSP services is denied such services, an appropriate referral may be provided.

1. Request for Second Opinion

a. If an initial applicant for CMHSP services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor, must be informed of their right to request a Second Opinion of the Executive Director or designee. The request shall be processed in compliance with Section 705 of the Michigan Mental Health Code and must be resolved **within 5 business days.**

1. The Executive director or 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.

2. If the individual providing the Second Opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or an intellectual/developmental disability, or is

experiencing an emergency situation or urgent situation, the community mental health services program shall direct services to the applicant.

2. Rights Complaint

The applicant or his/her guardian may **not** file a recipient rights complaint for denial of services suited to condition, as he/she does not have standing as a recipient of mental health services. The applicant or his/her guardian may, however, file a rights complaint if the request for a Second Opinion is denied.

3. Local Appeal

See Local Appeal Process section.

4. State Level

See State Fair Hearing Appeal Process section.

C. Denial of Service

Denial through the Service Authorization process of the request for Medicaid state plan, waiver, or additional mental health service **OR** denial of the requested amount, scope or duration of a service that was identified and agreed upon by the recipient during person-centered planning process.

1. Rights Complaint

The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Local Appeal

See Local Appeal Process section.

3. State Level

See State Fair Hearing Appeal Process section.

D. Suspension, Reduction, or Termination of a Currently Provided Service.

1. Rights Complaint

The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Local Appeal

See Local Appeal Process section.

3. State Level

See State Fair Hearing Appeal Process section.

E. Unreasonable Delay of Services

Unreasonable delay of a service beyond the start date agreed upon during the person-centered planning process and as authorized by the CMHSP. Unreasonable delay is defined as **14 or more calendar days.**

1. Rights Complaint

The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Local Appeal

See Local Appeal Process section.

3. State Level

See State Fair Hearing Appeal Process section.

F. Dissatisfaction with Program, Provider, Other

Dissatisfaction about any matter relative to a service other than an action as described above.

1. Grievance

See Grievance Local Process

2. Rights Complaint

If a complaint alleges a violation of a Mental Health Code protected right.

VI. GRIEVANCE PROCESS

A. Federal regulations provide recipients the right to a Grievance process to seek resolution to issues that are not Adverse Benefit Determinations.

B. Generally:

1. Recipients must file Grievances with the CMHSP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the recipient, guardian, or parent of a minor child or his/her legal representative.

3. Recipient's access to the State Fair Hearing process respecting Grievances is only available when the CMHSP fails to resolve the Grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process.

C. CMHSP Responsibility when Recipient Files a Grievance:

1. Provide recipients 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.

2. Acknowledge receipt of the Grievance.

3. Maintain a record of Grievances for review by the State as part of its quality strategy.

4. Submit the written Grievance to appropriate staff including a CMHSP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.

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

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

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

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

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the recipient a written notice of resolution not to exceed **90 calendar days** from the day the CMHSP received the Grievance.

2. Format and Content of Notice of Grievance Resolution:

a. Recipient notice of Grievance resolution must meet the requirements "…in a manner and format that may be easily understood and is readily accessible by such recipients and potential recipients," and meet the needs of those with limited English proficiency and or limited reading proficiency.

b. The notice of Grievance resolution must include:

i. The results of the Grievance process;
ii. The date the Grievance process was concluded;
iii. Notice of the recipient's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
iv. Instructions on how to access the State Fair Hearing process, if applicable.

VII. LOCAL APPEAL PROCESS (CMHSP)

A. Upon receipt of an Adverse Benefit Determination notification, federal regulations provide recipients the right to appeal the determination through an internal review by the CMHSP. Each CMHSP may only have one level of Appeal. Recipients may request an internal review by the CMHSP, which is the first of two Appeal Levels, under the following conditions:

1. The recipient has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal.

2. The recipient may request an Appeal either orally or in writing. Unless the recipient requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal.

NOTE: Oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the CMHSP will be

required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

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B. CMHSP Responsibilities when Recipient Requests an Appeal:

1. Provide recipients 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.

2. Acknowledge receipt of each Appeal.

3. Maintain a record of appeals for review by the State as part of its quality strategy.

4. Ensure that the individual(s) who make the decisions on Appeals:

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

   b. 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 recipient's condition or disease.

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

5. Provide the recipient a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing and inform the recipient of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals;

6. Provide the recipient and his/her representative the recipient's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the CMHSP 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.

7. Provide opportunity to include, as parties to the Appeal,

the recipient and his or her representative, or the legal representative of a deceased recipient's estate;

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

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The CMHSP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the recipient's health condition requires, but not to exceed **30 calendar days** from the day the CMHSP receives the Appeal.

2. Expedited Appeal Resolution (timing):

a. Available where the CMHSP determines (for a request from the recipient) or the provider indicates (in making a request on the recipient's behalf or supporting the recipient's request) that the time for a standard resolution could seriously jeopardize the recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

b. The CMHSP may not take punitive action against a provider who requests an expedited resolution or supports a recipient's appeal.

c. If a request for expedited resolution is denied, the CMHSP must:

i. Transfer the Appeal to the timeframe for standard resolution.

ii. Make reasonable efforts to give the recipient prompt oral notice of the denial.

iii. Within **2 calendar days**, give the recipient written notice of the reason for the decision to extend the timeframe and inform the recipient of the right to file a Grievance if they disagree with the decision.

iv. Resolve the Appeal as expeditiously as the recipient's health condition requires but not to exceed **30 calendar days.**

d. If a request for expedited resolution is granted, the CMHSP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-**

hours after the CMHSP receives the request for expedited resolution of the Appeal.

3. Extension of Timeframes: The CMHSP may extend the resolution and notice timeframe by up to **14 calendar days** if the recipient requests an extension, or if the CMHSP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the recipient's interest.

   a. If the CMHSP extends resolution/notice timeframes, it must complete all of the following:

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

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

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

4. Appeal Resolution Notice Format:

   a. The CMHSP must provide recipients with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution.

   b. Specifically, 42 CFR 438.416 indicates the State must require the CMHSP maintain records with (at minimum) the following information:

   (1) A general description of the reason for the Appeal or Grievance.
   (2) The date received.
   (3) The date of each review or, if applicable, review meeting.
   (4) Resolution at each level of the Appeal or Grievance if applicable.
   (5) Date of resolution at each level, if applicable.
   (6) Name of the covered person for whom the Appeal or Grievance was filed.

   Further this recordkeeping must be "accurately maintained in a manner accessible to the state and

available upon request to CMS."

c. Recipient notice must meet the requirements "…in a manner and format that may be easily understood and is readily accessible by such recipients and potential recipients," and meet the needs of those with limited English proficiency and or limited reading proficiency.

5. Appeal Resolution Notice Content:

a. The notice of resolution must include the results of the resolution and the date it was completed.

c. When the Appeal is not resolved wholly in favor of the recipient, the notice of resolution must also include notice of the recipient's:

i. Right to request a State Fair Hearing, and how to do so;

ii. Right to request to receive benefits while the State Fair Hearing is pending, and how to make the request; and

iii. Potential liability for the cost of those benefits if the hearing decision upholds the CMHSP's Adverse Benefit Determination

VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide a recipient 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:

1. After receiving notice that the CMHSP is, after Appeal, upholding an Adverse Benefit Determination.

2. When the CMHSP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals.

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the recipient, free to recipient, independent of State and CMHSP, and not extend any timeframes or disrupt continuation of benefits).

C. The CMHSP may not limit or interfere with a recipient's freedom to make a request for a State Fair Hearing.

D. Recipients are given **120 calendar days** from the date of the

applicable notice of resolution to file a request for a State Fair Hearing.

E. The CMHSP is required to continue benefits, if the conditions described in Section IV, "MEDICAID SERVICES CONTINUATION OR REINSTATEMENT" are satisfied, and for the durations described therein.

F. If the recipient's services were reduced, terminated or suspended without advance notice, the CMHSP must reinstate services to the level before the Adverse Benefit Determination.

G. The parties to the State Fair Hearing include the CMHSP, the recipient and his or her representative, or the representative of a deceased recipient's estate. A recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

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: www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid

OR

Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing
http://www.michigan.gov/lara

IX. RECORDKEEPING REQUIREMENTS

The CMHSP is required to maintain records of recipient Appeals and Grievances, which will be reviewed by the CMHSP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A CMHSP's record of each Grievance or Appeal must contain, at a minimum:

A. A general description of the reason for the Grievance or Appeal;

B. The date received;

C. The date of each review, or if applicable, the review meeting;

D. The resolution at each level of the Appeal or Grievance, if applicable;

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

F. Name of the covered person for whom the Grievance or Appeal was filed.

CMHSPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

X. RECIPIENT RIGHTS COMPLAINT PROCESS

Recipients, of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code.

CROSS REFERENCE:

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 18 Attachment P.6.3.1.1 Amendment #1

Michigan Mental Health Code, Chapters 7, 7A, 4 and 4A

42CFR 431.200 et seq.

42 CFR 438.400 et seq

CCMHS Clinical Guideline – Advance Notice for Medicaid or HM Recipients

CCMHS Clinical Guideline - Adequate Notice for Medicaid or HM Recipients