MCCMH MCO POLICY 2-009

(formerly known as "Consumer / Provider Grievances")

Category: **CLINICAL PRACTICE**
Title: **MEDICAID GRIEVANCES; NON-MEDICAID GRIEVANCES**

Prior Approval Date: 11/10/05
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Approved by: _____ 11/21/17
Executive Director Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health (MCCMH) Board for resolution of Consumer grievances.

II. Application

This policy shall apply to MCCMH administrative staff, directly-operated and contract network providers of the MCCMH Board, as well as to Medicaid Enrollees who are consumers of services provided through the MCCMH Prepaid Inpatient Health Plan (PIHP), and non-Medicaid consumers of Community Mental Health Services Plan (CMHSP) services.

III. Policy

It is the policy of the MCCMH Board to provide Consumers with:

A. An informal process through which they may seek resolution of Medicaid Grievances or Non-Medicaid Grievances; and

B. The services of an Ombudsman to mediate between providers and Consumers when Medicaid Grievances or Non-Medicaid Grievances arise.

IV. Definitions

A. Appeal: The local review by MCCMH of a Medicaid Adverse Benefit Determination, as requested by Medicaid Enrollee or authorized representative.

B. Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid Enrollees, and all other recipients of services provided by the MCCMH Community Mental Health Services Program (CMHSP). When the

word “Consumer” is used in this policy, it includes the Consumer, their Legal Representative, providers and other authorized representatives, to the extent described in Section V(D), below.

C. Inquiry: A request from a Consumer for information that would clarify policy, benefits, procedures, or any aspect of an administrative function but does not express dissatisfaction.

D. Legal Representative: An adult Consumer’s legal guardian, a minor Consumer’s parent or legal guardian.

E. Medicaid Adverse Benefit Determination: Any of the following, ***as it relates to Medicaid Enrollees, only***:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2. The reduction, suspension, or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service;

4. Failure to make a standard Service Authorization decision and provide notice about the decision within fourteen (14) calendar days from the date of receipt of a standard request for service (note: this timeframe may be extended up to an additional 14-calendar days in certain circumstances, as provided in MCCMH MCO 2-090, “Service Authorizations.”)

5. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization (note: this timeframe may be extended up to an additional 14-calendar days in certain circumstances, as provided in MCCMH MCO 2-090, “Service Authorizations.”).

6. The failure to provide services in a timely manner, as defined by the State – fourteen (14) calendar days of the start date agreed upon during the Person Centered Planning and as authorized by the PIHP;

7. Failure of the PIHP to resolve standard appeals and provide notice within thirty (30) calendar days from the date of a request for aa standard appeal;

8. Failure of the PIHP to resolve expedited appeals and provide notice within seventy-two (72) hours from the date of a request for an expedited appeal;

9. Failure of the PIHP to resolve grievances and provide notice within ninety (90) calendar days of the date of the request;

10. For a resident of a rural area with only one MCO, the denial of a Medicaid Enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or

11. The denial of a Medicaid Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Medicaid Enrollee financial liabilities.

F. Medicaid Enrollee: A Medicaid beneficiary who is currently a Consumer enrolled in the MCCMH PIHP.

G. Medicaid Grievance: An expression of dissatisfaction by a Medicaid Enrollee about any matter other than a Medicaid Adverse Benefit Determination. Medicaid Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or Consumer, or failure to respect the Medicaid Enrollee's rights regardless of whether remedial action is requested. Medicaid Grievance includes a Medicaid Enrollee's right to dispute an extension of time proposed by MCCMH to make a service authorization decision. An "Inquiry," as defined above, is not a Medicaid Grievance. Refer to MCCMH MCO 2.090, "Service Authorizations," for information regarding service authorization timing requirements.

H. Medicaid Grievance and Appeal System: The processes implemented by MCCMH to handle appeals of Medicaid Adverse Benefit Determinations and Medicaid Grievances, as well as the processes to collect and track information about them.

I. Medicaid Grievance Process: Impartial local review of a Medicaid Enrollee's Medicaid Grievance; a subpart of MCCMH's overarching Medicaid Grievance and Appeal System.

J. Non-Medicaid Adverse Benefit Determination: Also known as an "Action" or "Adverse Action", a Non-Medicaid Adverse Benefit Determination can be any of the following, ***as it relates to any Consumer***: (1) a denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a covered service; (4) the failure to

make an authorization decision and provide notice about the decision, within standard time frames; or (5) the failure to provide services within the applicable timeframe; (6) the failure of MCCMH to act within the timeframes required for disposition of grievances and appeals.

K. Non-Medicaid Grievance: Grievance raised by any Consumer regarding non-Medicaid/Medicare services which relates to the individual's general satisfaction with services and/or the process; an expression of dissatisfaction about any matter, service related, other than an Non-Medicaid Adverse Benefit Determination. An "Inquiry," as defined above, is not a Non-Medicaid Grievance.

L. Ombudsman: A MCCMH staff member of the Community Relations Office, whose role includes:

1. Helping Consumers voice their wishes and concerns so that they are heard and understood by MCCMH providers;

2. Facilitating resolution of Medicaid Grievances and Non-Medicaid Grievances;

3. Assisting Consumers with accessing the MCCMH Office of Recipient Rights (ORR) to pursue formal processes when a Mental Health Code issue arises (see MCCMH MCO Manual, chapter 9); and

4. Maintaining a web-based application documenting a record of Medicaid Grievances and Non-Medicaid Grievances in compliance with the Standards and Procedures defined herein.

M. State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of a Medicaid Adverse Benefit Determination presided over by a State hearing officer; also referred to as an "Administrative Hearing." (A Consumer with Medicaid coverage has the right to request a State Medicaid Fair Hearing to review a Medicaid Adverse Benefit Determination only after exhausting the Local Appeal Process; See MCCMH MCO Policy 9-171, "Local Appeal Process (Medicaid)."

V. Standards

A. Consumers shall have the right to initiate a Non-Medicaid Grievance in order to seek resolution to any issue that is not an appeal of a Non-Medicaid Adverse Benefit Determination or a Medicaid Adverse Benefit Determination, and that is not a Medicaid Grievance or a Medicare Grievance or Complaint.

B. For benefit of its Medicaid Enrollees, MCCMH shall maintain a Medicaid Grievance and Appeal System, which shall include a Medicaid Grievance Process that MCCMH Consumers shall have the right to access in order to seek resolution to any Medicaid Grievances which may arise.

C. The Ombudsman will ensure that any Non-Medicaid Grievance or Medicaid Grievance that involves rights protected by the Michigan Mental Health Code is routed to the MCCMH Office of Recipient Rights to proceed as a Recipient Rights Complaint.

D. Medicaid Grievances and Non-Medicaid Grievances may be filed by the Consumer or their Legal Representative. If a Medicaid Enrollee has provided written consent, the provider or other authorized representative may also act on the Medicaid Enrollee's behalf to file a Medicaid Grievance or request a State Fair Hearing. Punitive action may not be taken by MCCMH against a provider who so acts on the Medicaid Enrollee's behalf with their consent to do so.

E. Consumers may file Medicaid Grievances or Non-Medicaid Grievances, as appropriate, at any time, either orally or in writing. A Consumer is not prohibited from filing a Medicaid Grievance / Non-Medicaid Grievance simply because another issue is pending review pursuant to the Local Appeal Process or Local Dispute Resolution Process.

F. MCCMH will provide Consumers reasonable assistance with completing forms and taking other procedural steps related to their Medicaid Grievance/Non-Medicaid Grievance. This includes, but is not limited to, providing Consumers with auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.

G. MCCMH will acknowledge receipt of every Medicaid Grievance/Non-Medicaid Grievance, in writing.

H. MCCMH will provide Consumers with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments in support of their Medicaid Grievance.

I. MCCMH will ensure that individual(s) who make decisions on Medicaid Grievances:

    1. Were neither involved in the previous level review or decision-making on the issue, nor a subordinate of any such individual;

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

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

J. MCCMH will ensure that the process for resolving Non-Medicaid Grievances ensures that:

1. Individuals with the authority to require corrective action (authority to act upon the recommendations of the dispute resolution process – e.g., executive director or designee) are involved; and

2. The person reviewing the Non-Medicaid Grievance will not be the same person(s) who made the initial decision that is subject to the dispute.

K. Timeframe for Medicaid Grievance Resolution:

1. Unless the timeframe is extended as provided below, MCCMH must facilitate the Grievance Process as well as resolve the Medicaid Grievance and provide the Medicaid Enrollee with Notice of Grievance Resolution as expeditiously as the Consumer's health condition requires, and no more than 90-calendar days after receiving the Medicaid Grievance.

2. MCCMH may extend the standard timeframe for resolving a Medicaid Grievance and sending Notice of Resolution to the Consumer by up to fourteen (14) calendar days if:

i. The Medicaid Enrollee requests the extension; or

ii. MCCMH shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the Medicaid Enrollee's interest.

3. If MCCMH extends the timeframes (not at the request of the Medicaid Enrollee), it must complete all of the following:

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

ii. Within 2 calendar days give the Medicaid Enrollee written notice of the reason for the decision to extend the timeframe and inform the Medicaid Enrollee of the right to file a Medicaid Grievance if he or she disagrees with that decision; and

iii. Resolve the appeal as expeditiously as the Medicaid Enrollee's health condition requires and no later than the date the extension expires.

4. If MCCMH fails to adhere to these timing requirements, it will be considered a Medicaid Adverse Benefit Determination and the Consumer will be deemed to have exhausted the Appeals process; consequently, the Consumer will be permitted to initiate a State Fair Hearing.

5. Medicaid Grievances that are resolved within 90-calendar days (or up to 14-days thereafter, if properly extended as described above) are not subject to a State Fair Hearing.

L. Timeframe for Non-Medicaid Grievance Resolution:

1. Non-Medicaid Grievances shall be resolved by MCCMH within sixty (60) calendar days after it is initiated.

2. Non-Medicaid Grievances that are not timely resolved will be subject to the Local Dispute Resolution Process (See MCCMH MCO 9-170, “Local Dispute Resolution Process (All Consumers).”

M. Notice of Grievance Resolution: Within the appropriate timeframes, defined above, MCCMH shall provide the Consumer with a written Notice of Grievance Resolution.

1. Method: The Notice of Grievance Resolution will be provided to the Consumer using the method prescribed by the State, which shall, at minimum, meet the information requirement standards described in MCCH MCO 4-010, “Provision and Distribution of Information to Consumers.”

2. Content: The Notice of Grievance Resolution must include:

i. The results of the Medicaid Grievance Process;

ii. The date the Medicaid Grievance Process was concluded;

iii. For Medicaid recipients, notice of the Medicaid Enrollee's right to request a State Fair Hearing if the Notice of Grievance Resolution indicates that resolution did not occur within the required timeframe described above, with instructions on how the Medicaid Enrollee can access the State fair hearing process;

iv. For non-Medicaid recipients, notice of the Consumer's right to request a local appeal if the Notice of Grievance Resolution indicates that resolution occurred more than sixty (60) days from the date of the initiation of the Non-Medicaid Grievance, and instructions on how to access the Local Dispute Resolution Process.

N. External Medical Review**.** With respect to Medicaid Grievances, the State may offer and arrange for an external medical review if the following conditions are met:

1. The review must be at the Medicaid Enrollee's option and must not be required before or used as a deterrent to proceeding to the State Fair Hearing.

2. The review must be independent of both the State and the PIHP.

3. The review must be offered without any cost to the Medicaid Enrollee.

4. The review must not extend any of the timeframes specified in § 438.408 and must not disrupt the continuation of benefits in § 438.420.

O. MCCMH will accurately maintain a record of Medicaid Grievances and Non-Medicaid Grievances, in a manner that: (i) makes all records accessible to the State; (ii) makes records of Medicaid Grievances separately available upon request to the State and/or CMS; and (iii) contains sufficient information to reflect at least the following information:

1. A general description of the reason for each Medicaid Grievance / Non-Medicaid Grievance;

2. The date each Medicaid Grievance / Non-Medicaid Grievance was received;

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

4. Resolution at each level of the Medicaid Grievance / Non-Medicaid Grievance, if applicable;

5. Date of resolution at each level, if applicable;

6. Name of the covered person for whom the Medicaid Grievance / Non-Medicaid Grievance was filed;

P. MCCMH will provide information about the Medicaid Grievance Process and the process for resolving any Non-Medicaid Grievance to all contract network providers at the time of contracting.

Q. Any Consumer concern that is not a Medicaid Grievance or Non-Medicaid Grievance as defined by this policy, or that may also be resolved using another procedure, shall be handled according to the appropriate MCCMH MCO Policies, as follows:

1. Requests for re-determination of fees and appeals of fee determinations shall be made in accordance with MCCMH MCO Policy 7-001, "Determination of Financial Liability;"

2. Consumer requests for reconsideration of decisions regarding hospitalization/partial hospital admission (2nd opinion) shall be conducted in accordance with the MCCMH/Michigan Department of Health and Human Services (MDHHS) contract, MDHHS Medical Services Administration policies, the Michigan Mental Health Code and its Administrative Rules, and MCCMH MCO Policy 9-180, "Second Opinion Rights;"

3. New applicants for MCCMH services who have been denied entry into MCCMH services may request a second opinion as provided by the Michigan Mental Health Code, MCL 330.1705; MSA 14.800(705) and MCCMH MCO Policy 9-180, "Second Opinion Rights;"

4. Consumers who have a complaint relating to suspected recipient rights violations may initiate a formal complaint through the MCCMH ORR, as provided by MCCMH MCO Policy 9-510, "Recipient Rights Investigations;"

5. Consumers whose services have been reduced, suspended, or terminated, and have received a Notice of Non-Medicaid Adverse Benefit Determination, or who wish to dispute financial liability determinations or denial of family support subsidies, may request access to the Local Dispute Resolution Process pursuant to MCCMH MCO Policy 9-170, "Local Dispute Resolution Process (All Consumers)."

6. Medicaid Enrollees whose services have been reduced, suspended, or terminated, and have received a Notice of Medicaid Adverse Benefit Determination, may request access to the Local Appeal Process pursuant to MCCMH MCO Policy 9-171, "Local Appeal Process (Medicaid)."

R. The Ombudsman will provide annual reports of statistics and trends observed with respect to Medicaid Grievances / Non-Medicaid Grievances to the MCCMH Board. The annual report shall be reviewed by the MCCMH Quality Improvement Program in order to identify opportunities for improvement.

S. MCCMH shall not discriminate or retaliate against any Consumer who files a Non-Medicaid Grievances or Medicaid Grievance, or against any provider who participates in any grievance process on behalf of any Consumer.

VI. Procedures

A. Ombudsman:

1. If a Consumer desires assistance in the Medicaid Grievance Process, Non-Medicaid Grievance process, or the ORR process, the Consumer may contact the Ombudsman for assistance, either by phone or in writing.

2. The Ombudsman shall provide reasonable assistance with completing forms and taking other procedural steps related to the Medicaid Grievance Process. This may include, but is not limited to assisting the Consumer in obtaining interpreter services.

3. The Ombudsman will acknowledge receipt of each Medicaid Grievance / Non-Medicaid Grievance by letter to the Consumer. (See Exhibit A for an example of an acknowledgment letter)

4. The Ombudsman will notify the provider that a Consumer has requested assistance in resolving a Medicaid Grievance / Non-Medicaid Grievance.

5. The Ombudsman will assist the Consumer and provider with resolving the Medicaid Grievance / Non-Medicaid Grievance, and will

    i. Facilitate the Medicaid Grievance Process and resolve the Medicaid Grievance as expeditiously as the Consumer's health condition requires, in no event more than ninety (90) days after receiving the Medicaid Grievance (unless the timeframe is extended as provided below); and

ii. Facilitate the Non-Medicaid Grievance Process and resolve the Non-Medicaid Grievance as expeditiously as the Consumer's health condition requires and in no event more than sixty (60) days after receiving the Non-Medicaid Grievance.

1. The Ombudsman may, when appropriate in the interest of the Medicaid Enrollee and/or the proper resolution of the Medicaid Grievance, extend the standard timeframe for resolving a Medicaid Grievance and sending Notice of Resolution to the Consumer by up to fourteen (14) calendar days if the Medicaid Enrollee requests the extension or the Ombudsman can demonstrate that there is need for additional information and how the delay is in the Medicaid Enrollee's interest. In the case of such an extension, the MCCMH Ombudsman will:

    i. Document the reason for the extension;

    ii. Make reasonable efforts to give the Medicaid Enrollee prompt oral notice of the delay;

    iii. Within two (2) calendar days give the Medicaid Enrollee written notice of the reason for the decision to extend the timeframe and inform the Medicaid Enrollee of the right to file a Medicaid Grievance if he or she disagrees with that decision; and

    iv. Resolve the appeal as expeditiously as the Medicaid Enrollee's health condition requires and no later than the date the extension expires.

6. The Ombudsman will aid the Consumer in accessing the ORR to pursue formal processes when a question exists as to whether a Mental Health Code protected right violation has arisen. The ORR will investigate the nature of the potential rights violation, according to MCCMH MCO Recipient Rights Policies (see MCO Manual, Chapter 9.)

7. The Ombudsman will send a written Notice of Grievance Resolution to the Consumer, which notice will comply with the Timeframe, Method, and Content standards defined in Sections V(K)-(M), of this policy.

8. <u>Record of Medicaid Grievances / Non-Medicaid Grievances</u>:

    i. The MCCMH Ombudsman will maintain a record of Medicaid Grievances which shall be available for analysis by the MCCMH Quality Assessment and Performance Improvement Program

(QAPIP), and which shall comply with Section V(O). In addition, the record must contain the following information and supporting documentation:

a. Evidence of correspondence with the Consumer;

b. Criteria used to determine whether the issue was a recipient rights issue;

c. Proof that resolution was reached within the required time limits.

d. Actions taken by MCCMH to resolve Medicaid Grievances and other Consumer issues;

e. Follow-up with Consumers and/or MCCMH staff, as appropriate;

f. Observations of patterns and trends of Medicaid Grievances that can be analyzed as part of the MCCMH Quality Improvement Program to identify opportunities for improvement.

ii. The Ombudsman will maintain a record of Non-Medicaid Grievances which meets the same standards defined above in with respect to the Record of Medicaid Grievances, and which can be separated/extracted from the Medicaid Grievance records upon request.

iii. The record of Medicaid Grievances / Non-Medicaid Grievances, and supporting documentation, will be maintained by the Ombudsman using a web-based application.

B. MCCMH/ORR:

1. When a Medicaid Grievance is referred to the ORR by the Ombudsman, the ORR shall keep all documentation used in determining whether the issue was a recipient rights violation as evidence of an investigation/resolution process.

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2. If a Mental Health Code rights violation is in question, the Ombudsman and the ORR shall:

i. Inform the Consumer of the option to pursue the matter through the ORR complaint process; and

ii. Apply the standards and procedures for reporting, investigating, documenting and correcting alleged violations of recipient rights according to existing policies, in particular, MCCMH MCO Policy 9-510, "Recipient Rights Investigations."

3. The ORR shall inform non-Medicaid Consumers of the process for accessing the Local Dispute Resolution process in the event that a recipient rights complaint is not timely resolved. The ORR shall follow the standards and procedures of MCCMH MCO Policy 9-170, "Local Dispute Resolution Process (All Consumers)," in this event.

VII. References / Legal Authority

A. 42 CFR 438.400 - 438.424

B. Commission on Accreditation of Rehabilitation Facilities (CARF) Standards

C. MDHHS/CMHSP Specialty Services Managed Care Contract

D. MCCMH Policies 7-001, "Determination of Financial Liability" and 10-060, "Financial Liability Procedures"

E. MCCMH MCO Policy 9-170, "Local Dispute Resolution Process (All Consumers)"

F. MCCMH MCO Policy 9-171, "Local Appeal Process (Medicaid)"

G. MCCMH MCO Policy 9-180, "Recipient Rights - Second Opinion Rights"

H. MCCMH MCO Policy 9-510, "Recipient Rights Investigation"

I. MCCMH MCO Policy 9-606, "Dignity/Services Suited to Condition/Humane Treatment/Environment/Least Restrictive Treatment Environment"

VIII. Exhibits

A. Notice of Receipt of Appeal/Grievance

B. Notice of Grievance Resolution