MCCMH MCO Policy 4-004

Chapter: **CUSTOMER RELATIONS / MEMBER SERVICES**
Title: **DUE PROCESS SYSTEM**

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Proposed by: Dave Pankotai 02/24/2022
Chief Executive Officer Date

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I. ABSTRACT

This policy establishes the position statement of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, regarding MCCMH's adherence to and compliance with the legal requirements for the public behavioral health Prepaid Inpatient Health Plan (PIHP).

II. APPLICATION

This policy shall apply to the administrative offices and the directly-operated and contract network providers of the MCCMH Board.

III. POLICY

It is the policy of MCCMH that a due process system is established, maintained and in compliance with federal regulations to ensure all Medicaid beneficiaries the right to a fair and efficient process for resolving disagreements regarding their services and supports. An individual, or applicant 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 policy of MCCMH to follow all state and federal regulations regarding the resolution of complaints and disputes individuals may have about their services and supports.

This policy and any corresponding policies in no way requires the beneficiary to utilize due process prior to the filing of a Recipient Rights complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and affiliate policies relative to the filing of Recipient Rights complaints. This is also true for the Recipients Rights process for Substance Use Disorder services.

IV. DEFINITIONS

A. **Additional Mental Health Services:** Supports and services available to Medicaid beneficiary/beneficiaries who meet the criteria for specialty services and supports, under the authorization of Healthy Michigan, Habilitation Supports and Waiver and 1115/(i)SPA.

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

C. **Advance Notice of Adverse Benefit Determination:** Written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided/mailed to the Medicaid beneficiary at least ten (10) days prior to the proposed date the adverse benefit determination is to take effect.

D. **Adverse Benefit Determination:** A decision that adversely impacts a Medicaid beneficiary'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 within 14 calendar days from the date of receipt of a standard request for service authorization;
5. Failure to make an expedited authorization decision within seventy-two (72) hours from the date of receipt of a request for expedited service authorization;
6. Failure to provide service within the 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by MCCMH;
7. Failure of MCCMH to resolve standard appeals and provide notice of resolution within 30 calendar days from the date of a request for an appeal;
8. Failure of MCCMH to provide a notice resolution of a grievance/complaint within 90 calendar days of the date of the grievance filed; or
9. For residents of a rural area with only one provider, the denial of a beneficiary/beneficiaries' request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial responsibility.

E. **Appeal:** A review at the local level by MCCMH of an Adverse Benefit Determination.

F. **Applicant:** A person, or his/her legal representative, who makes a request for mental health or substance use disorder services.

G. **Authorization of services:** The processing of requests for initial and continuing service delivery.

H. **Beneficiary**: A Medicaid beneficiary who is currently enrolled at MCCMH in a managed care program.

I. **Consumer:** A broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by MCCMH, including Medicaid beneficiaries, and all other recipients of MCCMH's services.

J. **Due Process:** The process MCCMH implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

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

L. **Grievance:** A Medicaid beneficiary's expression of dissatisfaction about a service issue at MCCMH, 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 beneficiary, failure to respect the beneficiary's rights regardless of whether remedial action is requested, or a beneficiary's dispute regarding an extension of time proposed by MCCMH to make a service authorization decision.

M. **Grievance Process:** Impartial local level review of a beneficiary's grievance.

N. **Hearing Officer:** Staff person assigned to coordinate the State Fair Hearing process, representing MCCMH.

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

P. **Mental Health Professional:** A person who is trained and experienced in mental illness or intellectual/developmental disabilities, as identified per MDHHS staff qualification criteria.

Q. **Notice of Resolution:** Written statement from MCCMH of the resolution of a grievance or appeal, which must be provided to the beneficiary, as described in 42 CFR 438.408.

R. **Organizational Provider:** Entities under contract with MCCMH that directly employ and/or contract with individuals to provide specialty services and supports. Examples of organizational providers include, but are not limited to CMHSPs, hospitals, psychiatric hospitals, partial hospitalization programs, substance use disorder providers, case management programs, assertive community treatment programs, and skill building programs.

S. **PIHP:** An acronym for Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance use services in their geographic area under contract with the State. Each PIHP in Michigan is organized as a Regional Entity or a Community Mental Health Services Program according to the Mental Health Code.

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

U. **Second Opinion:** A request for another assessment by an applicant who has been denied mental health services or a recipient who is seeking and has been denied hospitalization.

V. **Service Authorization:** The processing of requests for initial and continuing authorization of services by MCCMH's Managed Care Operations Division (MCO), either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested.

W. **State Fair Hearing:** Impartial state level review for a Medicaid beneficiary's appeal of an adverse benefit determination, presided over by a MDHHS administrative law judge. Also referred to as "Administrative Hearing." This state fair hearing process is set forth in detail in Subpart E of 42 CFR part 431.

X. **Supervisor:** For this policy, and related policies, a supervisor can be at any level (e.g., the supervisor's supervisor).

V. STANDARDS

A. General Standards

1. Consumers of publicly funded services may access several options to pursue the resolution of complaints. These options include the right to file a local (internal) appeal, the right to a state fair hearing, the right to file a grievance, the right to file a recipient rights violation complaint, and the right to a second opinion.

2. During an individual's initial contact with the MCCMH Managed Care Operations Division (MCO), the individual shall be provided information on the due process system.

3. Individuals who wish to file a complaint may do so independently or with the assistance of MCCMH's Customer Service Division, 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 these processes have limited-English proficiency, MCCMH shall take all necessary and reasonable steps to make accommodations.

5. MCCMH shall provide information about the due process system to all providers and subcontractors at the time they enter a contract.

B. Grievances

1. Grievances are expressions of dissatisfaction about services other than adverse benefit determinations.

2. All grievances shall be resolved within 90 calendar days from the date of receipt.

3. A grievance may be filed at any time; there are no time limits.

4. A grievance may be filed by the beneficiary, guardian, parent of minor child, legal representative, or provider, with written permission from the person served indicating the wish to file a grievance.

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

6. All grievances must be logged, documented, and recorded and maintained in a secure location.

7. A state fair hearing is only allowed if the grievance is resolved past the 90-calendar day timeframe requirement.

8. MCCMH shall acknowledge, investigate, and provide resolution for substance use disorder (SUD) service-related grievances.

9. MCCMH shall designate at least one staff person to be responsible for facilitating the resolution of grievances. The designee shall:
    a. Acknowledge and log each grievance received;
    b. Ensure the individual(s) who make decisions of grievances are individuals:
        i. Who were not involved in any previous level of review or decision making;
        ii. Are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease;
        iii. Have the authority to require corrective action if necessary; and
        iv. Shall consider all comments, documents, records, and other information submitted by the beneficiary/representative without regard to whether such information was submitted or considered in the initial complaint.

10. A Resolution of Notice shall contain:
    a. The results of the grievance process;
    b. The date the grievance process was concluded;
    c. Notice of the beneficiary'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; and
    d. Instructions on how to access the state fair hearing process, if applicable.

11. Grievance records shall be maintained for review. MCCMH shall compile and submit all grievances to MDHHS on a quarterly basis.

C. Notice of Adverse Benefit Determination

1. MCCMH shall utilize the Notice of Adverse Benefit Determination as identified by MDHHS, for any decisions that adversely impact a beneficiary's services or supports.

2. The Notice shall meet the language format needs of the beneficiary, as specified in 42 CFR 348.10.

3. The Notice shall be in writing to the beneficiary, or the guardian on record.

4. The Notice shall include:
    a. A description of the determination (i.e., termination, denial, suspension, etc.);
    b. The reason for the determination;
    c. The policy/authority relied upon for making the determination;
    d. The effective date of the determination;

e. The right to file an appeal and instructions on how to do so;
f. The right to a state fair hearing should MCCMH fail to provide timely notice, or fail to provide notice of resolution within the required timeframes;
g. The circumstances under which an expedited appeal can be requested and instructions for doing so;
h. The explanation of representation options;
i. The right for the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination (including medical necessity criteria, processes, strategies, or evidentiary standards used in setting coverage limits);
j. The beneficiary's right to have benefits continue pending resolution of the appeal and instructions on how to request benefit continuation (Advance Notice Only); and
k. That 42 CFR 440.230(d) provides the basic legal authority for MCCMH to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

5. Timing of Notices:

a. Adequate notice is given/mailed to the consumer/guardian on the effective date. Adequate notice is used in the following determinations:
    1. Denial of payment for services requested (not currently provided), notice must be provided to the beneficiary at the time of the action affecting the claim;
    2. Denial of access into mental health services;
    3. Denial of access into substance use disorder programs;
    4. Denial or limited denial of requested services, amount, or duration of services:
        a) The Notice must be provided in writing to the beneficiary/guardian/parent of minor child within:
            i. 14 calendar days of a standard authorization request; or
            ii. 72 hours of an expedited authorization request.
        b) The Notice must be provided verbally or in writing to the requesting provider.

b. Service authorization decisions not reached within 14 days for a standard request, or 72 hours for an expedited request, constitutes a denial and is thus an adverse benefit determination, and notice must be sent to the beneficiary on the date the resolution time frames expire.
    1. MCCMH may be able to extend the standard service authorization timeframe in certain circumstances. If so, MCCMH must:

a) Provide the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision; and
b) Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

c. Advance Notice is given/mailed to a beneficiary/guardian a minimum of ten (10) calendar days prior to the effective date of the determination.
   1. The Advance Notice will contain language specifying that upon request, services and supports will remain in place and must be provided prior to a reduction, termination, suspension, or denial of services.
   2. Services will continue if a request is made within ten (10) days of the Advance Notice. Services will not be terminated if the authorization period has ended.
   3. Advance Notice is given for termination of services prior to the end of the current authorization.
   4. Advance Notice is given for a suspension or reduction in the amount of services prior to the end of the current authorization.
   5. Advance Notice is required even if the authorization has expired.

d. Exceptions to the advance notice, may occur in the following situations:
   1. There is factual information confirming the death of the beneficiary.
   2. MCCMH receives a clear written statement signed by a beneficiary that he/she no longer wishes services, or that gives information that requires the termination or reduction of services and indicates that the beneficiary understands that this must be the result of supplying that information.
   3. The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services. (For example, jail, prison, state hospital, extended care facility).
   4. There is established fact that the beneficiary has been accepted for Medicaid covered services by another local jurisdiction, state, territory, or commonwealth.
   5. The beneficiary's whereabouts are unknown, and the United States Post office returns agency mail directed to him/her indicating no forwarding address.
   6. A change in the level of medical care is prescribed by the beneficiary's physician.
   7. MCCMH has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by

the beneficiary (MCCMH has 5 days in these cases).

D. Appeal

1. Beneficiaries may pursue the option to dispute any Adverse Benefit Determination.
2. The Appeal is the first step of dispute and must be completed prior to the State Fair Hearing.
3. Beneficiaries are given 60 calendar days from the date of the Notice of Adverse Benefit Determination to request the Appeal.
4. A beneficiary may request an Appeal either orally or in writing.
5. The MCCMH Customer Service Division is the contact point when requesting a Local Appeal.
6. An organizational provider may file an appeal on behalf of a beneficiary as long as they have written permission from the beneficiary. MCCMH must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal. The provider may not request service continuation on behalf of the beneficiary.
7. Upon request, beneficiaries will be given assistance from staff in the appeal filing process, including explanation of the process and/or assistance completing forms. This also includes but is not limited to providing interpretive services, auxiliary aids and services upon request, and a toll-free number with interpreter capabilities.
8. Beneficiaries may request an expedited appeal. Documentation must show that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum functioning.
    a. If there is a denial of a request for the expedited appeal, MCCMH shall:
        i. Transfer the appeal to the timeframe for standard resolution;
        ii. Make reasonable efforts to give the beneficiary prompt oral notice or the denial and follow up within two (2) calendar days with a written notification; and
        iii. Provide the beneficiary the option to file a grievance about the denial of the expedited appeal request.
    b. If the request is granted, MCCMH shall resolve the expedited appeal and provide notice of resolution within 72 hours after MCCMH receives the request.

9. MCCMH may extend the timeframe of resolution of an appeal up to fourteen (14) additional calendar days if the beneficiary or provider requests an extension, or evidence can prove that the need for additional information will benefit the beneficiary. If MCCMH initiates the need for an extension, all the following must be met:
    a. MCCMH makes reasonable efforts to give the beneficiary prompt oral notice of the delay;
    b. Within 2 calendar days, MCCMH gives the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with the decision; and
    c. MCCMH resolves the appeal as expeditiously as the beneficiary's health condition requires and not later than the date the extension expires.

10. Beneficiaries must be provided a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing. In the case of an expedited request, the beneficiary must be notified of the limited time available.

11. Beneficiaries and/or representatives must be allowed the opportunity, before and during the appeal process, to examine the beneficiary's case file, including medical records and any other documents and records that were gathered during the appeal process.

12. MCCMH will ensure that the individual making the decision on an appeal:
    a. Was not involved in the previous level of review or decision-making, nor a subordinate of that individual;
    b. If deciding on an appeal that involved clinical issues, is a healthcare professional who has the appropriate clinical expertise, as determined by MDHHS, in treating the beneficiary's condition or disease;
    c. Considers 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.

13. MCCMH shall issue a written Notice of Resolution upon completion of an appeal investigation to the beneficiary. The Notice will be issued no later than 30 calendar days from the date of receipt of request for a standard appeal and 72 hours from the date of receipt of request for an expedited appeal.
    a. A Notice of Resolution shall contain:
        i. A general description of the reason for appeal;
        ii. The date received;
        iii. The date of the review process;
        iv. The results of the appeal process; and
        v. The date of resolution.
    b. If the resolution is not resolved wholly in favor of the beneficiary, the notice shall also include:

i. The right to a State Fair Hearing and instructions on how to file;
ii. The timeframe of no less than 90 calendar days and no greater than 120 calendar days to request a State Fair Hearing;
iii. The right to have services continue, if all conditions are met, and instructions on how to request service continuation;
iv. Potential liability for the cost of those benefits if the hearing decision upholds MCCMH's Adverse Benefit Determination.

E. State Fair Hearing

1. Beneficiaries have the right to an impartial review by a state level administrative law judge (State Fair Hearing), after receiving a Notice of Resolution of the Appeal upholding an Adverse Benefit Determination.

2. A State Fair Hearing is allowed if MCCMH fails to adhere to the notice and timing requirements for the resolution of grievances and appeals.

3. MCCMH may not limit or interfere with a beneficiary's freedom to make a request for a State Fair Hearing.

4. Beneficiaries are given no less than 90 calendar days and no greater than 120 calendar days from the date of the Notice of Resolution from the internal appeal process to file a State Fair Hearing.

5. Beneficiaries may request service continuation if:
   a. All conditions are met, as described in section V.F of this policy; and
   b. The request was made within 10 calendar days of the date of the Notice of Resolution from MCCMH.

6. If the beneficiary's services were reduced, terminated, or suspended without advance notice, MCCMH must reinstate services to the level before the Adverse Benefit Determination.

7. The parties to the State Fair Hearing include MCCMH, the beneficiary and his/her representative.

8. The Recipient Rights Officer shall not be appointed as the Hearings Officer due to the inherent conflict of roles and responsibilities.

9. Expedited State Fair Hearings are available.

F. Continuation of Benefits Pending Appeal

1. The beneficiary may request services to continue while waiting for an appeal if all the following are true:
   a. The beneficiary files the appeal in a timely manner, within 10 calendar days of the date of the notice, before or on the effective date indicated on the notice;
   b. The appeal involves an Adverse Benefit Determination of termination, reduction, or suspension of a previously authorized service; or
   c. An authorized provider ordered services.

2. Benefits must continue (if all conditions above are met) until one of the following occurs:
   a. The beneficiary withdraws the appeal;
   b. The beneficiary fails to request a State Fair Hearing and continuation of benefits within 10 days after MCCMH sends the beneficiary the Notice of Resolution, upon completion of the appeal;
   c. The State Fair Hearing Office issues a hearing decision adverse to the beneficiary; or
   d. The duration of the previously authorized service has ended.

3. If the beneficiary's services were reduced, terminated, or suspended without an advance notice, MCCMH must reinstate services to the level before the action.

G. Record Keeping

1. MCCMH maintains records of beneficiary grievances and appeals.

2. Records shall contain the following:
   a. A general description of the reason for the grievance or appeal;
   b. The date received;
   c. The date of review;
   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. The name of the covered person for whom the grievance or appeal was filed.

3. MCCMH shall maintain records accurately and in a manner accessible to the State and available upon request to CMS and MDHHS.

VI. REFERENCES / LEGAL AUTHORITY

A. 42 CFR 438 et. Al.

B. Subpart E of 42 CFR 431.

C. MDHHS/PIHP Contract Attachment 6.3.1.1

D. MDHHS/CMHSP Contract Attachment 6.3.2.1

E. MI Mental Health Code

F. Administrative Rules

VII. EXHIBITS

None.