Policy: Appeal & Grievance/Fair Hearings/Second Opinion 11-B		Application: BCCMHA Staff & Providers
Reviewed 5/3/2023	Revised 5/3/2023	First Effective 10/13/1999

I. PURPOSE

To assure that the appeal and/or grievance process for clients complies with federal and state laws including, but not limited to, Office of Recipient Rights, Social Security Act, Michigan Mental Health Code, the Balanced Budget Act of 1997, and Due Process Clause of the US Constitution.

To set forth steps to ensure due process when services are reduced, suspended, terminated, and/or denied.

To set forth expedited steps for addressing emergency appeals/grievances.

To provide for a process of tracking and analyzing client appeals and grievances.

II. POLICY

All service clients have the right to a fair and efficient process for resolving complaints regarding the services and/or supports managed and/or delivered by BCCMHA and/or Southwest Michigan Behavioral Health (SWMBH), the Prepaid Inpatient Health Plan (PIHP*)*. As such, all clients of, or applicants for, public behavioral health will receive notice of their rights and an explanation of the grievance and appeal resolution process.

The appeal and grievance process for clients will promote the resolution of the client's concerns as well as support and enhance the overall goal of improving the quality of care. The goals of the appeal and grievance process are the assurance of covered services appropriate to the client's condition and the protection of rights guaranteed by law.

Appeal and grievance processes implemented by BCCMHA (directly or through SWMBH) will be timely, fair to all parties, administratively simple, objective and credible, accessible and understandable to all clients, cost and resource-efficient, and subject to review by the Quality Improvement System, Customer Service and governing body.

Procedures will also assure clients, or their legally appointed representative, are provided with information and assistance as needed throughout the appeal and grievance process. This includes providing reasonable assistance to complete forms and take other procedural steps for both grievance and appeals, including, but 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.

Appeal and grievance processes will not interfere with communication between the client and the service provider(s). There will be no discrimination or retaliation toward a client or a service provider for initiating or participating in the grievance and/or appeal process.

The Michigan Mental Health Code states, "An individual shall not be denied services because of the

inability of the responsible parties to pay for services" (330.1810). This is supported by BCCMHA.

Denial, reduction, suspension or termination of service may occur due to client lack of eligibility, unavailability of the service as a covered benefit, the level of medical or clinical necessity presented by the client, failure to justify the use of a covered service, and so on. The appeal and grievance mechanism allows clients the ability to challenge these service decisions. BCCMHA will provide the client, or their representative, with a reasonable opportunity to present evidence of fact or law in person as well as in writing. The client, or their representative, will be provided with an opportunity before, during and after the appeals process to examine the client's medical record and any other documents or records considered during appeals and/or grievance processes. Please see the Confidentiality Policy.

BCCMHA will address recuse by ensuring that the individual(s) or staff resolving the appeal was not involved in the previous level of review or decision-making, nor a subordinate of any such individual. Those involved with the decision-making process associated with both grievances and appeals will be qualified mental health or substance use disorder treatment professionals with appropriate clinical expertise to support issues involving medical necessity or other clinical issues. Selection of the qualified health professional will not be conditional to the professional's involvement within or outside of the agency's provider network.

It is the desire of BCCMHA to have all disputes resolved at the level closest to the service delivery. The BCCMHA client appeal and grievance process and supporting policies shall serve as the standard appeal and grievance mechanism for clients. The Medicaid beneficiary's right to file a fair hearing request with the Michigan Department of Health and Human Services (MDHHS) cannot be initiated until the local appeal process has been completed. However, if BCCMHA fails to adhere to the notice and timing requirements, a request for a State Fair Hearing may be filed.

For each denial of inpatient care or eligibility for an initial service at the time of the denial, BCCMHA is required to provide the client, his or her guardian, or a minor applicant's parents with written Notice of the Rights to a Second Opinion and the process for doing so. Second opinions are made available at no cost to beneficiaries from a qualified health professional within the network or outside the network if a qualified health professional is not available within the network under Section 438.206(b) of the Balanced Budget Act.

BACKGROUND

Conceptually, the grievance system divides client complaints into two categories: 1) Those challenging an action, an appeal; 2) those challenging anything else, a grievance. Appeal and grievance process can often be complex and confusing to clients. The client should experience "no wrong door" when he/she wishes to appeal or file a grievance. The appeal and/or grievance can be placed in writing or orally.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continue benefits pending a final decision; and (4) a timely decision,

measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provide a process to help protect Medicaid Enrollee due process rights. There is also a Dispute System for non-Medicaid consumers. Please see the Local Dispute Resolution Process Policy.

Clients of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid Enrollees who participate in managed care:

- ✓ State fair hearings through authority of 42 CFR 431.200 et seq.
- ✓ Local appeals through authority of 42 CFR 438.400 et seq.
- ✓ Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7, 7A, 4, and 4A, including:

- ✓ Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- ✓ Medical second opinion through authority of the Mental Health Code (MCL 330.1705)
- ✓

III. STANDARDS

Federal regulation (42 CFR 438.228) requires the State to ensure through its contracts that a grievance and appeal system is in place for Enrollees that comply with Subpart F of Part 438. Although this technical advisory specifically addresses the federal Grievance System process for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced. Please see the Local Dispute Resolution Process Policy for information about the grievance and appeal system for non-Medicaid consumers.

The Grievance and Appeal System must provide Enrollees:

- ✓ An appeal process (one level only) which enables Enrollees to challenge Adverse Benefit Determinations made by BCCMHA and 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 local level Appeal.
- ✓ Information that if BCCMHA fails to adhere to notice and timing requirements as outlined in the PIHP Appeal Process, the Enrollee is deemed to have exhausted the appeals process. The enrollee may initiate a State Fair hearing.
- ✓ The right to request, and have, Medicaid covered benefits continued while a local level appeal and/or State Fair Hearing is pending.
- ✓ With the written consent from the Enrollee, the right to have a provider or other authorized representative acting on the Enrollee's behalf file an Appeal or Grievance

to BCCMHA or request a State Fair Hearing. The provider may file a grievance or request for 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. The identified authorized representative must also sign the consent. Punitive action may not be taken by BCCMHA against a provider who acts on the enrollee's behalf with the enrollee's written consent to do so.

The Grievance and Appeal System must provide non-Medicaid beneficiaries:

- ✓ A local dispute resolution process to address decisions by BCCMHA and/or its provider network that impact the consumer's access to, or satisfaction with, services and supports.
- ✓ The local dispute resolution process at a minimum must possess the following characteristics:
    - Provide for a timeframe in which a consumer has to initiate a local dispute thirty (30) days from the time Notice is received (for reduction, suspension or termination)
    - Provides for prompt resolution; 45 calendar days for local appeals and 60 calendar days for local grievance
    - Assures the participation of individuals with the authority to require corrective action. Someone with the authority to act upon the recommendations of the dispute resolution must be involved. This would include the Executive Director or designee
    - Assures that the person reviewing the local appeal or local grievance will not be the same person(s) who made the initial decision that is subject to dispute or is a subordinate of the person involved in the grievance.
    - Provides a mechanism for expedited review of a local appeal involving denial of psychiatric hospitalization. NOTE: Applicants and consumers are entitled to a second opinion, under the Code for this same type of denial
    - Provides the consumer with written notification of the local dispute resolution process decision and subsequent avenues available to the consumer if he or she is not satisfied with the result, including the right of consumer without Medicaid coverage to access the MDHHS Alternative Dispute Resolution process after exhausting local dispute resolution procedures
        - Provides reports of local disputes, i.e., local appeals and grievances periodically to the BCCMHA governing body
        - Reports of local disputes will be reviewed by the BCCMHA Quality Improvement Program to identify opportunities for improvement
        - Record of local disputes must be made available to the MDHHS for review upon request

A notice of Adverse Benefit Determination will be provided to a client when a service authorization decision constitutes an action by authorizing a service in amount, duration, or scope less than requested or less than currently authorized, or the service authorization is not made timely. In these situations, BCCMHA will provide a notice of action containing additional information to inform the client of the basis for action taken, or intends to take and the process available to appeal the decision.

The notice of Adverse Benefit Determination must be either an adequate notice or an advance notice. The adequate notice being provided to the client at the time of each action and the advance notice being provided when an action is being taken to reduce, suspend, or terminate services that a client is currently receiving. The advance notice must be mailed/provided ten (10) calendar days before the intended action takes effect for Medicaid consumers and thirty (30) calendar days before the intended action takes effect for non-Medicaid consumers.

LOCAL DISPUTE RESOLUTION FOR NON-MEDICAID CONSUMERS

The client or the legally empowered guardian expresses a desire to appeal a decision to deny, suspend, reduce or terminate services at the local level. This may be communicated to any behavioral worker, customer services representative, the local office of Recipient Rights, or the Regional Service Representative. The initial contact person will assist the client/guardian with formulating the request for a local dispute resolution (LDRP) and will advise a client of their rights, written or orally, for appeal/grievance. See the Local Dispute Resolution Process Policy for details.

ADVANCE NOTICE

Advance Notice of Adverse Benefits Determination is a written notice required when an action is being taken to reduce, suspend, or terminate services that the client is currently receiving. The advance notice must be mailed so that the client is provided at least 10 calendar days' notice before the intended action takes effect for Medicaid consumers and 30 calendar days' notice for non-Medicaid consumers.

The content of the notice will:

- ✓ Be in writing and will meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such Enrollees and potential Enrollees" and meets the needs of those with limited English proficiency and/or limited reading proficiency).
- ✓ Include notification that 42 CFR 440.230(d) 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.
- ✓ Contain a description of Adverse Benefit Determination.
- ✓ The reason(s) for the Adverse Benefit Determination and policy/authority relied upon in making the determination.
- ✓ Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits).
- ✓ Notification of the Enrollee's right to request an Appeal, including information on exhausting BCCMHAs Appeal process, and the right to request a State Fair Hearing or Alternative Dispute Resolution Process thereafter.
- ✓ Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal.
- ✓ Notification of the Medicaid Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit

continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only when providing "Advance Notice of Adverse Benefit Determination").

- ✓ Description of the procedures that the Enrollee is required to follow to exercise any of these rights.
- ✓ An explanation that the Enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.

There are limited exceptions to allow BCCMHA to mail an adequate notice of action not later than the date of action to terminate, suspend, or reduce previously authorized services, IF: (42 CFR 431.213; 42 CFR 431.214)

- ✓ BCCMHA has verified information confirming the death of the Enrollee
- ✓ BCCMHA receives a clear and written statement signed by the Enrollee that she/she no longer wishes services, or that gives information that requires termination or reduction of services, and indicates the Enrollee understands this must be the result of supplying that information
- ✓ The Enrollee has been admitted to an institution where he/she is ineligible under the plan for further services
- ✓ The Enrollee's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address
- ✓ BCCMHA establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth
- ✓ A change in the level of medical care is prescribed by the Enrollee's physician
- ✓ The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the SSA
- ✓ The date of the action will occur in less than 10 calendar days
- ✓ BCCMHA has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case, BCCMHA may shorten the period of advance notice to 5 calendar days before the date of action)

For non-Medicaid beneficiaries, actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

ADEQUATE NOTICE

Adequate notice is a written notice provided to the client at the time of each action. The plan of service, developed through a person-centered planning process and finalized with the client, must include, or have attached, the adequate notice provisions. The content of the notice will include an explanation of BCCMHA's intended action to be taken, reason for the action, and the legal authority for the action to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures. Information within the adequate notice informs the client of their right to appeal, if the client has a right to request a state fair hearing and instruction for doing so. The notice of action must be mailed at the time of the decision to deny payment for a service; within 14 calendar days of the request for a standard service authorization decision to deny or limit services; or within 72 hours of the request for an expedited service authorization decision to deny or

limit services. For service authorization decisions not reached within 14 calendar days for standard request or 72 hours for an expedited request (which constitutes a denial and is thus an adverse benefit determination), notice must be mailed on the date the timeframes expire (42 CFR 438.404(c)(5)).

NOTE: BCCMHA may be able to extend the standard (14 calendar day) or expedited (72 hour) Service Authorization timeframes for up to an additional 14 calendar days if either the Enrollee requests the extension, or if BCCMHA can show there is a need for additional information and the extension is in the Enrollee's best interest (42 CFR 438.210(d)(1)(ii)). If BCCMHA extends the time NOT at the request of the Enrollee, BCCMHA must: (i.) make reasonable efforts to give the Enrollee prompt oral notice of the delay; (ii.) within 2 calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he/she disagrees with that decision; and (iii.) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

DENIAL OF FAMILY SUPPORT SUBSIDY

If an application for a family support subsidy is denied or a community mental health services program terminates a family support subsidy, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the community mental health services program. The hearing shall be conducted in the same manner as provided for contested case hearings under Sections 24.271 to 24.287 of the Michigan Compiled Laws.

Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from BCCMHA. In lieu of a standardized form, families may be asked to write a letter to BCCMHA requesting an appeals hearing.

BCCMHA shall review an application for subsidy and promptly approve or deny the application and shall provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny application. If the denial is due to insufficiency of the information on the application form or the required attachments, BCCMHA shall identify insufficiency and provide opportunity for the family to obtain and provide that information. If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be presented to BCCMHA within two months (60 days) of the notice of denial or termination.

SECOND OPINIONS AND DENIAL OF HOSPITALIZATION

If an inpatient psychiatric pre-admission screening requested by the individual, their guardian, parent of a minor child, or designated patient advocate, executed by BCCMHA or designated screening unit denies hospitalization, a request for a second opinion may be made at no cost to the client. The request for the second opinion shall be processed in compliance with the Michigan Mental Health Code (Sections 409(4), 498e(4), and 498h(5). If the conclusion of the second opinion is different from the conclusion of the inpatient psychiatric pre-admission screening, the Executive Director, in conjunction with the Medical Director shall review the second opinion and make a decision based upon all clinical information available within one business day, excluding Saturdays, Sundays and holidays. If the request for a second opinion is denied, the client or someone on his or her behalf

may file a Recipient Rights Complaint with the local Recipient Rights Office.

A recipient, who is denied hospitalization by the pre-admission screening unit (PSU), may request a second opinion, and that 1) the Executive Director will arrange the second opinion to be performed within 3 days (excluding Sundays and holidays), 2) the Executive Director, in conjunction with the Medical Director, will review the second opinion if it differs from the opinion of the PSU, and 3) the Executive Director will make a decision to uphold or reject the findings of the second opinion, and 4) confirm that decision, in writing, to the requestor; written decision will be signed by the Executive Director and by the Medical Director (or provide verification that the decision was made in conjunction with the Medical Director). [MHC 1409(4)]

The Executive Director's decision to uphold or reject the findings of the second opinion is confirmed in writing to the requestor; this writing contains the signatures of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director.

If the initial request for inpatient psychiatric admission is denied, and the client is a current recipient of other behavioral health services, the client or someone on his/her behalf may file a Chapter 7 complaint alleging a violation of his/her right to treatment suited to condition. If the second opinion determines the client is a current recipient of other behavioral health services, and a recipient rights complaint has not been filed previously on behalf of the client, the client or someone on his/her behalf may file a complaint with the BCCMHA's Recipient Rights Office for processing under Chapter 7A.

DENIAL OF AGENCY SERVICES

If an initial applicant for behavioral services is denied such services, the applicant or his/her guardian, parent of a minor child, or designated patient advocate will be informed of their right to request a second opinion to determine if the applicant has a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency situation or urgent situation of the Executive Director at no cost to the individual. [MHC 1705(1)(2)/RR Standard L1] The request will be processed in compliance with the Michigan Mental Health Code (Section 705) and will be resolved within five business days. The applicant may not file a recipient rights complaint for denial of services; however, he/she may file a rights complaint if the request for a second opinion is denied. It should be noted that those individuals seeking substance use disorder services and addiction treatment are not afforded the right to a second opinion under the Michigan Mental Health Code and will be provided with a Notice of Adverse Benefit Determination.

STATE FAIR HEARING:

Federal regulations provide a Medicaid Enrollee the right to an impartial review by a state level administrative law judge (A State Fair Hearing), of a decision made by the local agency or its agent.

- A Medicaid Enrollee or Enrollee's Representative has the right to request a Medicaid Fair Hearing only after receiving notice that BCCMHA is upholding the Adverse Benefit Determination. This request must be submitted within 120 calendar days from the date of the Adverse Benefit Determination being upheld or a grievance request is not acted upon within 90 calendar days. The beneficiary does have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary.

- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP, the beneficiary and his/her representative, or the representative of a deceased estate. A Recipient Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- Expedited hearings are available.

MAINTAINING SERVICES AND SUPPORTS

If an appeal is about changes to services that the Enrollee is currently receiving, the Enrollee has the right to have those services continue during the appeal. BCCMHA or SWMBH **must** continue Medicaid services previously authorized while the appeal and/or State Fair Hearing are pending if:

- ✓ The Enrollee files the request for continuation of benefits timely on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended date of the proposed Adverse Benefit Determination, and
- ✓ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
- ✓ The services were ordered by an authorized provider; and
- ✓ The original period covered by the original authorization has not expired.

When BCCMHA or SWMBH continues or reinstates the client's services while the appeal is pending, the services must be continued until one of the following occurs:

- ✓ The client or client's representative withdraws the appeal.
- ✓ Ten calendar days pass after BCCMHA/SWMBH mails the Adverse Benefit Determination of the appeal, unless the client or client's representative within the 10-calendar day timeframe has requested a State Fair hearing with continuation of services until a State Fair Hearing decision is reached.
- ✓ A State Fair Hearing officer issues a hearing decision adverse to the client or client's representative.
- ✓ The time period or service limits of the previously authorized services has been met.

If SWMBH or the Michigan Department of Health and Human Services Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the client received the disputed services while the appeal was pending, SWMBH or the State must pay for those services in accordance with State policy and regulations.

If SWMBH or the Michigan Department of Health and Human Services Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, SWMBH or BCCMHA must authorize or provide the disputed services promptly, and as expeditiously as the client's health condition requires.

NOTIFICATION

Clients will receive written information concerning their rights as recipients of behavioral health services. This includes the appeals and grievance process. This information will be provided as a routine part of the intake process, annually thereafter.

When a service recipient appeals a service request or files a complaint, BCCMHA will make contact with that client, either by phone or in writing, to acknowledge receipt of the appeal or complaint and immediately begin the resolution process.

The client will receive written notice of the decision resulting from an appeal, grievance or complaint regarding the denial, reduction, suspension or termination of services and supports. In situations involving an external service provider, a written notice will also be given to the provider outlining any decisions to deny, limit, or discontinue authorization of services.

REINSTATEMENT OF SERVICES

BCCMHA may reinstate services if an Enrollee or his/her legal representative requests a MDHHS hearing not more than 10 days after the date of Adverse Benefit Determination. The decision to reinstate services will be made by the Executive Director. Possible reason for reinstatement can include any of the following:

1. Failure to provide Advance Adverse Benefit Determination.
2. Request for a Fair Hearing was made within 10 days of the notice of Adverse Benefit Determination.
3. Action resulted from factors other than the application of Federal or State Law or policy.
4. The action may result in serious, adverse harm to the individual or the community.
5. The whereabouts of the service recipient were unknown as indicated by undeliverable mail and the whereabouts became known during the time of service eligibility.

EXCEPTIONS

Clients who are not currently receiving behavioral health services may not file a recipient rights complaint nor may they request a fair hearing from the MDHHS. They may, however, file a complaint or request a hearing if they are denied the right for a second opinion when BCCMHA services or hospitalization are denied.

Clients who are not Medicaid recipients must first file a dispute with the Customer Service Representative before filing a request for an Alternative Dispute Resolution. If the findings are not consistent with the facts or with law, rules, policies or guidelines, the client may then request access to the MDHHS Alternative Dispute Resolution Process. MDHHS will review such requests within two business days and will attempt to resolve the issue with the client within 15 business days. Recommendations of MDHHS are not binding where the decision poses no immediate impact to the health and safety of the client.

IV. PROCEDURES

When services for a client are denied, reduced, suspended or terminated, the Appeals/Grievance and Fair Hearing guidelines and policy will be used to determine what appropriate actions are to be taken

and followed through.

The client will receive adequate notice at the Person Centered Planning (PCP) meeting and/or case review (Periodic or Quarterly Review) of any changes to be made to services that the client is receiving. Upon the decision of the client, he/she may file an appeal, grievance, or complaint. The appeal, grievance or complaint is addressed and the designated staff person who has that authority renders a decision. The client will then be provided with the decision in writing.

> NOTE: All grievances and complaints are routed through the local Customer Services Representative.

At the time of the annual PCP meeting, the primary clinician/case manager provides the client with adequate notice of the person's right to appeal the service plan. The client may then request a fair hearing only after completing the local dispute process.

The local Customer Service Representative and/or health plan customer service representative will help the client understand and access options available for appeal/complaint/grievance resolution. The Customer Service Representative will log all local disputes and fair hearings.

LOCAL GRIEVANCE PROCESS

In complying with federal regulations, BCCMHA will provide Medicaid beneficiaries information about the local grievance process for issues that are not "actions." For each grievance filed, BCCMHA Customer Service Representative is required to:

- Acknowledge the receipt of the Grievance in writing to the member or complainant if other than the member.
- Log receipt of the Grievance for reporting to SWMBH and internally.
- Assess whether the Grievance is a Recipient Rights issue and provide assistance as needed to file a recipient rights complaint with the Recipient Rights officer.
- Provide the beneficiary reasonable assistance to complete forms and take other procedural steps, including but not limited to, translation and literacy support.
- Ensure the individual(s) resolving the Grievance were not involved in the previous level review or decision-making or a subordinate of the person involved with the grievance.
- Ensure that individual(s) who makes the decisions on the Grievance is a health care professional with appropriate clinical expertise in treating the beneficiary's condition or disease if the Grievance:
  -involves clinical issues, or
  -involves the denial of an expedited resolution of an appeal (of an action).
- Take into account all comments, documents, records and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.t
- Submit the written Grievance to appropriate staff including a BCCMHA administrator with the authority to require corrective active, none of who shall have been involved in the initial determination.
- Provide the beneficiary with ***written*** notice within 90 calendar days from the date the Grievance was received. The content of the Notice of Disposition much include:

-The results of the grievance process.
-The date the grievance process was concluded.
-The Medicaid beneficiary's right to request a local appeal or a fair hearing if the notice of disposition is more than 90 days from the date of the request for a grievance.
-How to access the fair hearing process.

Beneficiary Grievances

- Shall be filed with the Customer Service Unit responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian or parent of a minor child or his/her legal representative.
- Do not have access to the State Fair Hearing process unless, BCCMHA fails to respond to the grievance within 90 calendar days. This constitutes an "action" and can be appealed for fair hearing to the MDCH Administrative Tribunal.

LOCAL APPEAL PROCESS

In complying with federal regulations, BCCMHA will provide Enrollees information about the right to a local level appeal of an "Action". The Enrollee or their representative may file an appeal with the Customer Service Representative under the following conditions:

- ✓ It has been no more than 60 calendar days from the date of the notice of action;
- ✓ An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request may be confirmed in writing, if more information or clarification is needed, but not if the beneficiary requests expedited resolution. (There is an expedited review process for appeals when the PIHP determines (from a request from the client) or the provider indicates (in making a request on the customer's behalf or supporting the customer's request) that taking the time for the standard resolution could seriously jeopardize the client's life or health or ability to attain, maintain or regain maximum function.)
- ✓ The request is made by the client, provider (acting on the client's behalf and with consent) or other legal representative.

When a local appeal is requested, BCCMHA shall:

- ✓ Ensure that the verbal request for an appeal establishes the earliest filing date.
- ✓ Acknowledge the receipt of the appeal in to the client and/or person requesting the appeal on behalf of the client;
- ✓ Log receipt of the request for an appeal;
- ✓ Provide the client reasonable assistance to complete forms and 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.
- ✓ Ensure that the individual(s) who make the decisions on the Appeals:
    - Were not involved in any previous level review or decision-making, nor a subordinate of any such individual.
    - When deciding an Appeal that involves either (i) clinical issues, or (ii) denial based on lack of medical necessity, are individual(s) who have appropriate

clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.
    - Take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- ✓ Provide the client or representative with:
    - Reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and/or in writing and inform them of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals
    - Opportunity before, during and after the appeal process to examine the client's case file, including medical records and any other documents or records considered during the appeals process sufficiently in advance of the resolution timeframe;
    - Opportunity to include, as parties to appeal, the client's and his or her representative or the legal representative of a deceased client's estate;
    - Information regarding the right to a Fair Hearing and the process to request this hearing if covered by Medicaid.
    - The case file, at no cost, including medical records, any documents and any new or additional evidence that was used to make the adverse benefit determination.

Please see the Local Dispute Resolution Process policy for guidance on grievance and appeal (dispute) processes for non-Medicaid consumers.

NOTICE OF DISPOSITION REQUIREMENTS

BCCMHA will provide written notice of the disposition of the appeal to the Enrollee within 30 calendar days from the date the appeal was received. In the event that the client requests an extension, or BCCMHA is able to satisfy the State's requirements for an extension, BCCMHA may extend this timeframe by up to 14 calendar days. In the event of an expedited appeal, BCCMHA shall provide notice of disposition no longer than 72 hours after the appeal was requested and granted. If request for an expedited appeal was denied, reasonable efforts must be made to provide the client prompt oral notice of the denial, and must be given written notice within two calendar days. Denied requests for an expedited appeal shall then be subject to the timeframe for standard resolution. The appeal will be resolved as expeditiously as the client's health condition requires and no later than the date of the standard resolution timeframe. The written notice shall include an explanation of the results of the resolution and the date it was completed.

When the appeal is not wholly in favor of the Enrollee, the notice of disposition must also include:

- ✓ The right to request a State Fair Hearing and how to do so;
- ✓ The right to request to receive benefits while the State Fair Hearing is pending if requested within 10 calendar days of BCCMHA mailing of the notice of disposition and how to make the request;

REPORTING REQUIREMENTS

BCCMHA shall maintain logs of any and all denials of services, adhering to the established reporting guidelines applicable to grievance and appeals and second opinion requirements. All denials of services for Medicaid beneficiaries will be reported to SWMBH. In addition, BCCMHA will document requests for second opinions. All second opinions associated with Medicaid beneficiaries will be entered into the SWMBH Grievance, Appeals, and Second Opinion Database directly by designated staff. The Customer Service Representative will maintain grievance service system records of appeals and grievances for review as part of the service system to support and enhance the quality of care.

Type	Reporting Requirement
Grievance	Acknowledgement letter of grievance received should be sent.
Grievance Outcome	Acknowledgement of the outcome of the grievance should be sent within 90 days of filing.
Appeal	Decision should be made as quickly as possible but no longer than 30 calendar days from the date it was filed.
Expedited Appeal	No longer than 72 hours from the date the expedited appeal was requested.

The Customer Service Representative is responsible for maintaining and submitting local data to SWMBH Customer Services who will monitor, track and trend all denials, state fair hearings, grievance and appeals and second opinion requests and dispositions for Medicaid beneficiaries.

REFERENCE AND CITATION SECTION

42 CFR 438.10(f)(4), (f)(6)
42 CFR 438.100
42 CFR 438.206(b)(3)
42 CFR 438.210 et seq.
42 CFR 438.225
42 CFR 438.228
42 CFR 438.400 et seq.
42 CFR 438.404 (a) et seq.
42 CFR 438.406(a)(2)
42 CFR 438.406(b)(2)(i)
MCL 330.1772 et seq.
MCL 330.1705
R 330.1616
R 330.1641
R 330.1643
Due Process Clause of the US Constitution
Medicaid Master Contract Attachment P. 6.3.2.1.
General Fund Master Contract Attachment C.6.3.2.1.
MDHHS Grievance and Appeal Technical Requirement (Attachment P 6.3.1.1)
Section 942 of P.A. 269 of 2016

ATTACHMENTS

See Appeal and Grievance/Fair Hearing/Second Opinion Forms Packet

APPROVED BY:

Richard Thiemkey Date
Executive Director