I. **POLICY:**

Community Mental Health of Ottawa County (CMHOC) will provide for a fair and efficient process for resolving reduction, suspension, termination, or denial of service as well as, Medicaid and non-Medicaid grievances.

II. **PURPOSE:**

To ensure all individuals receiving services from CMHOC have a right to a fair and efficient process for resolving grievances and disputes related to the denial, reduction, suspension, or termination of services and supports. This policy in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Mental Health Code and Affiliate policies relative to the filing of Recipient Rights Complaints.

III. **APPLICATION:**

All mental health programs, services, and facilities directly operated by or under contract with CMHOC.

IV. **DEFINITIONS:**

A. **Action:**

1. Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.
2. Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.
3. Denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service.
4. Failure to make an authorization decision and provide notice about the decision within standard time frames.
5. Failure to provide Medicaid or non-Medicaid services within standard time frame.
6. In regard to Medicaid covered services, failure of the CMH to act within the time frames required for disposition of grievances and appeals.

B. **Adequate Notice:**

Written statement advising the individual of a decision to deny or limit authorization of Medicaid services requested. Notice to individual on the same date each action takes effect or at the time of the signing of the individual plan of services/supports.
C. **Advance Notice:**

Written statement advising the individual of a decision to reduce, suspend, or terminate Medicaid services currently provided. Notice to be provided/mailed at least twelve (12) calendar days prior to the proposed date the action is to take effect.

D. **B3 Services:**

A set of MDHHS and CMS approved services which may be provided under the authority of Section 1915(b)(3) of the Social Security Act. The intent of B3 Services (formerly known as alternative services) is to fund medically necessary supports and services that promote community inclusion and participation, independence and/or productivity when identified in the individual plan of service as one or more of the goals developed during the Person-Centered Planning process.

E. **Appeal:**

A request for a review of an action (as defined above) relative to a Medicaid covered service or non-Medicaid covered service.

F. **Grievance:**

An expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, other than an action as defined above, which does not involve a Recipient Rights complaint as defined in Section I. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the individual.

G. **Medicaid Covered Service:**

A Medicaid State Plan, B3, Children’s Waiver, Children’s SED Waiver, or Habilitation Supports Waiver service as defined in the most recent version of Chapter III of the Michigan Department of Community Health, Medical Services Administration Bulletin.

H. **Reasonable Person:**

A phrase frequently used in Tort and Criminal Law to denote a hypothetical person in society who exercises average care, skill, and judgment in conduct and who serves as a comparative standard for determining liability.

I. **Resolution Notice:**

Notice to the individual that is required within established time frames relative to the disposition of grievances and resolution of appeals and disputes.

J. **Rights Complaint:**

A written or verbal statement by an individual or anyone acting on behalf of an individual alleging a violation of a Code-protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

V. **PROCEDURE:**

A. Notice is given whenever a Medicaid State Plan, B3, or Waiver Service is denied, reduced, suspended, or terminated. The notice must be in writing and must be provided in the language...
format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency).

B. Actions not related to second opinions:

**PROCEDURE FOR ACTIONS NOT RELATED TO SECOND OPINIONS**

<table>
<thead>
<tr>
<th>Action</th>
<th>Type of Notice</th>
<th>Time frame for Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial of service request</td>
<td>Adequate</td>
<td>At the time of decision</td>
</tr>
<tr>
<td>Person-Centered Plan developed</td>
<td>Adequate</td>
<td>At the time of plan development</td>
</tr>
<tr>
<td>Increase in benefits</td>
<td>Adequate</td>
<td>At the time of the action</td>
</tr>
<tr>
<td>Reduction, suspension or termination of service currently being received</td>
<td>Advance</td>
<td>Twelve (12) calendar days before action</td>
</tr>
<tr>
<td>Standard authorization decision that denies or limits services requested</td>
<td>Adequate</td>
<td>Within fourteen (14) calendar days from the date of receipt of a request*</td>
</tr>
<tr>
<td>Expedited authorization decision that denies or limits services requested</td>
<td>Adequate</td>
<td>Within three (3) working days from the date of receipt of a request*</td>
</tr>
<tr>
<td>Unreasonable delay of start of services</td>
<td>Adequate</td>
<td>At the time of the action</td>
</tr>
</tbody>
</table>

*The timeframe may be extended up to another fourteen (14) calendar days at the request of the individual or provider or if the CMHOC shows to the satisfaction of the State there is a need for additional information and how the delay is in the individual’s interest. **Note:** If an individual's physician makes a determination that a particular Medicaid State Plan or Waiver service is not medically needed, no adverse action occurred. In these instances, an advance notice of adverse action is not required.

1. The written notice of action (as defined above) must contain the following:
   a. The action taken or intends to take.
   b. The reasons for the action.
   c. The date of the intended action.
   d. If access to services or hospitalization is denied, the right to request a second opinion, and an explanation of the process.
   e. The individual’s right to file an appeal, dispute, and/or rights complaint (the latter is relative only to the suspension, reduction, or termination of a service or the denial of hospitalization) and the time frames for doing so.
   f. In regard to Medicaid covered services, the individual’s right to request a MDHHS Fair Hearing and the timeframes for doing so.
   g. The procedures for exercising the resolution options.
   h. The circumstances under which expedited resolution is available and how to request it.
   i. In regard to Medicaid covered services, the individual’s right to have benefits continue pending resolution of the appeal or MDHHS Fair Hearing decision, how to request that benefits be continued, and the circumstances under which the individual may be required to pay the costs of these services. The notice must specify that if the individual requests a MDHHS Fair Hearing prior to the date of action (i.e., suspension, reduction, or termination of a Medicaid covered service).
service), in most circumstances CMHOC may not reduce, suspend, or terminate the services until a decision is rendered after the hearing.

2. Time frames for written notice of action: CMHOC must mail/provide the notice to the individual within the following time frames:
   a. For termination, suspension or reduction of previously authorized or provided services at least twelve (12) calendar days before the date of action. (Advance Notice)
   b. At the time of the decision to deny payment for a service. (Adequate Notice)
   c. For authorization or service decisions that deny or limit services within fourteen (14) calendar days of the standard request for services, or three (3) working days of the request for expedited authorization. If either of these time frames is extended at the individual's or provider's request (up to an additional fourteen (14) calendar days), CMHOC must give the individual written notice of the reason for the extension, and inform the individual of the right to file a grievance if dissatisfied with the decision to extend. Affiliates will issue and carry out its determination as expeditiously as the individual's health condition requires and no later than the date the extension expires. (Adequate Notice)
   d. For authorization decisions that are not made within fourteen (14) calendar days (or three (3) working days for expedited authorization), and for which an extension has not been agreed to, a notice must be provided to the individual on the fourteenth (14th) day, (or third (3rd) working day for an expedited authorization).
   e. In the case of the written individual plan of service/support (IPOS), at the time the plan is signed by the individual, his/her guardian, or parent of a minor individual. If mailed, the Adequate Notice provisions must be attached. (Adequate Notice)

3. Exceptions to the Advance Notice Rule: In addition to B.2. above, CMHOC may mail a notice not later than the date of action if:
   a. It has factual information confirming the death of the individual.
   b. The Affiliates receive a clear written statement signed by the individual or his/her legal representative that:
      i. He/she no longer wishes services; or
      ii. Gives information that requires termination or reduction of services and indicates he/she understands this must be the result of supplying the information.
   c. The individual has been admitted to an institution where he/she is ineligible under Medicaid for further services.
   d. The individual's whereabouts are unknown and the post office returns CMHOC’s mail directed to him/her indicating no forwarding address.
   e. It establishes the fact that the individual has been accepted for Medicaid services by another PIHP.
   f. A change in the level of medical care is prescribed by the individual’s physician.
   g. The date of the action will occur in less than ten (10) calendar days.

C. Maintaining Medicaid-covered services and supports.

1. If the Affiliate mails the advance notice of action impacting Medicaid covered services as required above and the individual served by the Medicaid program or his/her legal representative requests a MDHHS Fair Hearing before the date of action in lieu of, or in addition to, filing an appeal, the Affiliate may not terminate or reduce services until a decision is rendered after the hearing unless:
   a. It is determined at the hearing the sole issue is one of Federal or State law, AND
b. CMHOC promptly (i.e., in the advance notice) informs the individual that services are to be terminated, reduced or suspended pending the MDHHS hearing decision.

2. If CMHOC’s action is sustained by the Fair Hearing Decision, CMHOC may seek reimbursement from the individual for the cost of any services provided the individual during this period of time, up to the individual’s ability to pay as determined by the Code.

3. If CMHOC, or the DCH Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the individual received the disputed services while the appeal was pending, CMHOC or the State must pay for those services in accordance with State policy and regulations.

4. If CMHOC, or the DCH Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, CMHOC must authorize or provide the disputed services promptly, and as expeditiously as the individual’s health condition requires.

D. Reinstatement of Medicaid covered services.

1. CMHOC must reinstate Medicaid covered services if an individual or his/her legal representative requests a MDHHS Fair Hearing not more than twelve (12) calendar days after the date of action.

2. The reinstated Medicaid covered services must continue until the hearing decision unless, at the hearing, it is determined the sole issue is one of Federal or State law or policy.

3. CMHOC must reinstate and continue Medicaid covered services until a hearing decision, if:

   a. Action was taken without the required advance notice; AND
   b. The individual or his/her legal representative requests a hearing within twelve (12) calendar days of the mailing of the notice of action; AND
   c. The Affiliate determines the action resulted from factors other than the application of Federal or State law or policy.

4. If an individual’s whereabouts are unknown as indicated by return of non-forwardable mail from CMHOC, any discontinued Medicaid State Plan or Waiver services must be reinstated if his/her whereabouts become known during the time he/she is eligible for services.

E. Provider’s Right to Appeal.

1. A provider acting on behalf of a Medicaid eligible individual and with the individual’s written consent may file an appeal to CMHOC. The provider may file a grievance or request for a State hearing on behalf of the individual only if the State permits the provider to act as the individual’s authorized representative in doing so.

2. The requesting provider, in addition to the individual, must be provided notice of any decision by CMHOC to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice of action to the provider is not required to be in writing.

3. Punitive action may not be taken by CMHOC against a provider who acts on the individual’s behalf with the individual’s written consent to do so.
## F. APPEALS AND GRIEVANCE RESOLUTION PROCESSES

<table>
<thead>
<tr>
<th>Action</th>
<th>Local Processes</th>
<th>State Level Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial of request for hospitalization&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Step 1. Request a 2nd Opinion, then Step 2. Complaint to the Office of Recipient Rights</td>
<td>Step 1 or 2. Request for a Fair Hearing (for Medicaid beneficiaries)</td>
</tr>
<tr>
<td>Denial of access to PIHP/CMHSP services&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Step 1. Request a 2nd Opinion</td>
<td>Step 1 or 2. Request for Fair Hearing (for Medicaid beneficiaries)</td>
</tr>
<tr>
<td>Denial, reduction, suspension, termination, or unreasonable delay of Medicaid services&lt;sup&gt;1, 2&lt;/sup&gt;</td>
<td>Step 1 or 2. Appeal to the Local Dispute Resolution Process and/or,</td>
<td>Step 1 or 2. Request for Fair Hearing (for Medicaid beneficiaries)</td>
</tr>
<tr>
<td>Dissatisfaction with program, provider, other&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Step 1 or 2. Complaint to the Office of Recipient Rights (treatment suited to condition)</td>
<td></td>
</tr>
<tr>
<td>Denial of Family Support Subsidy&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Step 1. Appeal to CMHSP</td>
<td>Step 2. MDHHS Alternative Dispute Resolution Process</td>
</tr>
</tbody>
</table>

1. Action taken at the time of Person-Centered planning, or as an outcome of the service authorization process or management decision.
2. Medicaid beneficiaries are not required to exhaust local dispute processes before they request a Medicaid Fair Hearing.

**Note about the steps:** The Local Dispute Resolution Process may be engaged concurrently with an appeal to ORR, and/or request for State Fair Hearing, unless otherwise noted. The individual is entitled to the formal processes if he/she chooses even if a mediation process is available.

G. Second Opinions.
PROCEDURE FOR SECOND OPINIONS

1. Denial of hospitalization – Any or all of the following processes may be utilized:
   a. Request for Second Opinion:
      i. If a Pre-Admission Screening Unit or Children’s Diagnostic and Treatment Service of the Affiliate denies hospitalization, the individual, his/her guardian, or his/her parent in the case of a minor child, may request a second opinion from the Executive Director of CMHOC.
      ii. The request for the second opinion shall be processed in compliance with Sections 409(4), 498e (4) and 498h (5) of the Code. If the conclusion of the second opinion is different from the conclusion of the Children’s Diagnostic and Treatment Service or the Pre-Admission Screening Unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based upon all clinical information available within one (1) business day.
   b. Rights Complaint:
      i. If the request for a second opinion itself is denied, the individual or someone on his/her behalf may file a rights complaint with CMHOC’s Office of Recipient Rights for processing under Chapter 7A.
      ii. If the initial request for inpatient admission is denied, and the individual is a current beneficiary of CMHOC services, the individual or someone on his/her behalf may file a rights complaint alleging a violation of his/her right to treatment suited to condition.
      iii. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current beneficiary of CMHOC services, and a Recipient Rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the Rights Office for processing under Chapter 7A.
   c. Appeal- See Local Appeals Resolution Requirements and Process.
   d. MDHHS Level:
      i. Medicaid Fair Hearing: For Medicaid beneficiary appeals on actions that impact Medicaid covered services.
      ii. MDHHS Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

2. Denial of access to any services for individuals not receiving any of CMHOC’s services, any or all of the following processes may be utilized:
   a. Request for Second Opinion:
      If an initial applicant for public mental health services is denied such services, the applicant or his/her guardian, or the applicant’s parent in the case of a minor must be informed of their right to request a second opinion of the Executive Director. The request shall be processed in compliance with Section 705 of the Code and must be resolved within five (5) business days.
   b. Rights Complaint:
      The applicant or his/her guardian may not file a recipient rights complaint for denial of services suited to condition as he/she does not have standing as a beneficiary of mental health services. The applicant or his/her guardian may, however, file a recipient rights complaint if the request for a second opinion is denied.
c. Appeal: Please see the Local Appeals Resolution Requirements and Process.

d. MDHHS Level:
   i. Medicaid Fair Hearing: for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
   ii. MDHHS Alternative Dispute Resolution: for appeals on actions that impact non-Medicaid covered services.

3. Denial through the service authorization process of the request for Medicaid State Plan, B3, or Waiver, or denial of the requested amount, scope or duration of a service that was identified and agreed upon by the individual during Person-Centered planning. Any or all of the following processes may be utilized.
   a. Rights Complaint.
   b. Appeal - See Local Appeals Resolution Requirements and Process.
   c. MDHHS level:
      i. Medicaid Fair Hearing: For Medicaid beneficiary appeals on actions that impact Medicaid covered services.
      ii. MDHHS Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

4. Unreasonable delay of a Medicaid State Plan, B3, or Waiver beyond the start date agreed upon during Person-Centered planning and as authorized by the Affiliates. Unreasonable delay is defined as fourteen (14) or more calendar days. Any or all of the following processes may be utilized.
   a. Rights Complaint.
   b. Appeal - See Local Appeals Resolution Requirements and Process.
   c. MDHHS level:
      i. Medicaid Fair Hearing: For Medicaid beneficiary appeal on actions that impact Medicaid covered services.
      ii. MDHHS Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

5. Suspension, reduction, or termination of a current Medicaid State Plan, B3, or waiver: Any or all of the following processes may be utilized:
   a. Rights Complaint.
   b. Appeal - See Local Appeals Resolution Requirements and Process.
   c. MDHHS level:
      i. Medicaid Fair Hearing: For Medicaid beneficiary appeals on actions that impact Medicaid covered services.
      ii. MDHHS Alternative Dispute Resolution: For appeals on actions that impact non-Medicaid covered services.

6. Dissatisfaction about any matter relative to a Medicaid State Plan, B3, or Waiver other than an action as described above.
   a. Grievance – See Grievance Process. Possible subjects include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a provider and the individual.
   b. Rights Complaint: Statements or allegations, verbal or written, by the individual or anyone acting on his/her behalf that allege a violation of a Code-protected rights cited in Chapter 7 will be resolved through processes established in Chapter 7A.
VI. APPEAL OF DENIAL OF FAMILY SUPPORT SUBSIDY:

A. Demand for CMHSP Hearing and Appeal.

1. Pursuant to Section 159(3) of the Code, if an application for a family support subsidy is denied or a family support subsidy is terminated by a Community Mental Health Services Program (CMHSP), the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the CMHSP. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, and being Sections 24.271 to 24.287 of the Michigan Compiled Laws.

2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the CMHSP. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form.)

3. A CMHSP shall review an application, promptly approve or deny the application, and provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. (Rule R330.1641 Application review)

4. If an application is denied or the subsidy is terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the CMHSP within two (2) months of the notice of the denial or termination (R330.1643 Appeal).

5. If the MDHHS representative, using a “reasonable person” standard, believes that the denial or termination of the subsidy will pose an immediate and adverse impact upon the individual’s health and safety, the issue is to be referred within one (1) business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDHHS/CMHSP contract.

Michigan Department of Community Health
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DCH Level Dispute Resolution
Lewis Cass Building – 6th Floor
Lansing, MI 48913

VII. MEDICAID FAIR HEARING REQUIREMENTS:

For beneficiaries receiving Medicaid Covered services, CMHOC must comply with applicable sections of Federal Law 42 CFR 431.200-250 regarding Fair Hearings, as defined through the MDHHS policy communications listed as references at the end of the policy.

Note: Access to the Fair Hearing process applies to all beneficiaries who receive or request Medicaid covered services, including B3 Services and the Habilitation and Supports Waiver for persons with Developmental Disabilities and the Children’s Waiver.

The individual who has received notice of an action has the right to request a Fair Hearing with a MDHHS Administrative Law Judge. Beneficiaries are given ninety (90) calendar days from the date on the notice to file a request for Fair Hearing. They may concurrently file an appeal for Local Resolution. If the individual files a request for Fair Hearing prior to the Affiliate taking an adverse action, the Affiliate must continue the service and not take the action until a Fair Hearing decision has been made.
Please refer to MDHHS’s Administrative Hearings Policy for detailed information and instructions about the Medicaid Fair Hearings process.

[Note: Failure to make an authorization decision and provide written notice within fourteen (14) calendar days of receipt of a non-emergent request for a service constitutes a service denial or adverse action. Failure to make authorization decisions within three (3) working days after the receipt of an urgent (i.e., following a standard time frame for authorization could seriously jeopardize the individual’s health condition) request for service constitutes a service denial or adverse action. The Affiliate may extend either time frame up to fourteen (14) additional calendar days if the individual or provider requests an extension.]

VIII. MDHHS ALTERNATIVE DISPUTE RESOLUTION PROCESS:

A. Within ten (10) days of receipt of the written decision on the Local Dispute (appeal or grievance), the individual, his/her guardian, or parent of a minor individual may file a request for a MDHHS level Dispute Resolution to:

Michigan Department of Community Health
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DCH Level Dispute Resolution
Lewis Cass Building – 6th Floor
Lansing, MI 48913

B. If the MDHHS representative, using a “reasonable person” standard, believes the denial, suspension, termination, or reduction of the services and/or supports will pose an immediate and adverse impact upon the individual’s health and safety, the issue is to be referred within one (1) business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDHHS/PIHP contract.

In all other cases, MDHHS shall complete its review of the dispute within fifteen (15) business days of receipt. Written notice of the resolution shall be submitted to the individual, his/her guardian, or parent of a minor beneficiary.

CMHOC must provide reports of disputes, complaints, and grievances periodically to its Governing Board with a copy to the PIHP Regulatory Management staff.

Reports of disputes, complaints, and grievances are to be reviewed by the Affiliate’s Quality Improvement Program to identify opportunities for improvement. The Affiliate’s Quality Improvement Program must send a copy of its actions to the PIHP Regulatory Management staff.

IX. RECORDKEEPING AND REPORTING REQUIREMENTS:

CMHOC must maintain a record of appeals and grievances and their disposition that is available for review by State staff. CMHOC must forward their record of appeals and grievances to the PIHP Regulatory Management staff in January and June of each calendar year.

X. LOCAL APPEALS RESOLUTION REQUIREMENTS AND PROCESS:

A. Special Requirements for Appeals. The process for appeals must:

1. Provide that oral requests for appeal of an action are treated as appeals (to establish the earliest possible filing date for the appeal). The oral request must be confirmed in writing, unless the individual requests an expedited resolution.
2. Give the individual reasonable assistance in completing forms and taking other steps to complete the appeals process. This assistance includes, but is not limited to, Interpreter Services, and CMHOC’s toll-free numbers that have TTY/TTD and interpreter capability.
These numbers are to be found in the Member Handbook, brochures, and on the notice forms.

3. Provide the individual a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (CMHOC must inform the individual of the limited time available for this in the case of expedited resolution.)

4. Provide the individual and his/her representative the opportunity, before and during the appeals process, to examine the individual's case file, including medical records, and any other documents considered during the appeal process.

5. Include, as parties to the appeal:
   a. The individual and his/her representative; or
   b. The legal representative of a deceased individual's estate.

6. If the individual, or representative, requests a local appeal not more than twelve (12) calendar days from the date of the notice of action, CMHOC must reinstate the Medicaid services until disposition of the hearing.

B. Appeal Process:

1. Within forty-five (45) calendar days of receipt of the action notice, the individual or his/her legal representative, or the provider on his/her behalf, may file an appeal with the local Fair Hearing Officers Office which shall then:
   a. Log receipt of the appeal for reporting and tracking purposes.
   b. Acknowledge receipt of the appeal; and for a Medicaid beneficiary disputing an action that impacts a Medicaid covered service, advise the individual, guardian, or in the case of a minor, the parent, that he/she may file a request for a MDHHS Fair Hearing in lieu of, or in addition to, the appeal. Information shall include the process for filing the request for a hearing, an offer of assistance in filing the request and an explanation of time frames and circumstances under which Medicaid services will be continued pending the hearing decision.
   c. Submit the appeal for review by appropriate staff, including a health care professional who has the appropriate clinical expertise in treating the individual's condition, with none having been involved in the initial determination to deny, suspend, terminate, or reduce the Medicaid covered service.
   d. Facilitate the review of the appeal within forty-five (45) calendar days from receipt of the appeal.
   e. Assure an expedited review of an appeal involving an emergent situation where the standard forty-five (45)-day time frame would seriously jeopardize the health or life of the individual or ability to attain, maintain, or regain maximum function. Such a review shall be completed within three (3) working days of receipt of the appeal.
   f. Assure the content of the resolution notice and time frame for submission to the individual and his/her legal representative complies with the Resolution Notice requirements.

2. Resolution Notice:
   a. Content of resolution notice: Written notice of the appeal resolution must include:
      i. The results of the resolution process and the date it was completed.
      ii. For appeals not resolved wholly in favor of the Medicaid beneficiary disputing action taken that impacts Medicaid covered services:
         a. The right to request a MDHHS Fair Hearing, and how to do so, including an offer of assistance;
         b. The right to request to receive services while the hearing is pending, if requested within twelve (12) calendar days of the Affiliate mailing the notice of disposition, how to make the request, including an offer of assistance; and
         c. The individual may be held liable for the cost of those services if the hearing decision upholds CMHOC's action.
iii. For appeals not resolved wholly in favor of the individual who is disputing action taken that impacts non-Medicaid covered services:
a. The right to seek MDHHS alternative dispute resolution, how to do so, and an offer of assistance.

iv. For appeals resolved to the satisfaction of the individual or his/her legal representative, an explanation of, and an offer of assistance in the process for withdrawing any request filed for a MDHHS Fair Hearing.

b. Timing of Resolution Notice:

i. Written notice of the appeal resolution must be submitted to the individual and his/her legal representative within forty-five (45) calendar days following receipt of the appeal.

ii. For notice of an expedited appeal, CMHOC must make reasonable efforts to provide oral notice as soon as possible followed by written notice within three (3) working days following the receipt of the request for expedited resolution of the appeal.

iii. CMHOC may extend the notice of disposition time frame by up to fourteen (14) calendar days if the individual requests an extension, or if CMHOC shows to the satisfaction of the State there is a need for additional information and how the delay is in the individual’s interest.

iv. If CMHOC denies a request for expedited resolution of an appeal, it must:
(a) Transfer the appeal to the time frame for standard resolution or no longer than forty-five (45) days from the date CMHOC receives the appeal;
(b) Make reasonable efforts to give the individual prompt oral notice of the denial; and
(c) Give the individual follow-up written notice within two (2) calendar days.

XI. GRIEVANCE PROCESS:

A. The individual, guardian, parent of a minor child, or his/her legal representative may file a grievance at any time regarding dissatisfaction with any aspect of service provision other than an adverse action as defined in this requirement or an allegation of an individual rights violation. The individual must be given reasonable assistance in completing forms for filing a grievance. The grievance shall be filed with the CMHOC’s Customer Services Department.

B. The Customer Services Department shall then:

1. Log receipt of the verbal or written grievance for reporting and tracking purposes.
2. Determine whether the grievance is more appropriately an individual Recipient Rights complaint, and if so, refer the grievance, with the individual’s permission, to the Office of Recipient Rights.
3. Acknowledge to the individual the receipt of the grievance.
4. Submit the written grievance to the appropriate staff including an Affiliate administrator with the authority to require corrective action. Further, no staff members making decisions on the grievance shall have been involved in the original determination.
5. Individuals making the decision on the grievance will be health care professionals 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.

6. Facilitate resolution of the grievance within thirty (30) calendar days of receipt of the grievance.

7. Within thirty (30) calendar days of a decision by the Affiliates regarding the grievance, notification of the outcome of the process is provided to the individual, guardian, or parent of a minor child.

8. Provide a written disposition within sixty (60) calendar days of CMHOC’s receipt of the grievance to the beneficiary, guardian, or parent of a minor child.

The content of the notice of disposition includes:

- The date the grievance process was concluded;
- The results of the grievance process; and
- The beneficiary’s right to request a Fair Hearing if the notice is more than sixty (60) calendar days from the date of the request for a grievance; and how to access the Fair Hearing process.

XII. REFERENCES:

PA 516 of 1996
PA 258 of 1974, as amended
S.353-Health Insurance Bill of Rights of 1997
42 CFR Chapter IV, Subpart E, Sections 431.200 et seq
42 CFR Chapter IV, Subpart F, Sections 438.402 to 424
MDHHS-MSA Policy Bulletin: Hourly Home Care - Criteria for Determining Number of Hours (Children’s Waiver)
MDHHS FY14 Amendment #1, Contract Attachment P6.3.2.1