

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Reporting Medicaid Beneficiary Appeals, Grievances, Recipient Rights and State Fair Hearings		
Policy: <input type="checkbox"/> Procedure: <input checked="" type="checkbox"/> Version: 2.0 Page 1 of 3	Review Cycle: Annually Author: Chief Compliance Officer, Customer Service Committee	Adopted Date: 05.18.2015 Review Date: 12.18.2017 Revision Eff. Date:	Related Policies: Customer Services Policy Medicaid Beneficiary Appeals/Grievances Policy

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Purpose

To establish a process for Community Mental Health Service Program (CMSHP) Participants to report the status of State Fair Hearings and Recipient Rights to Mid-State Health Network (MSHN). Also, to establish a process for Community Mental Health Services Program (CMHSP) Participants and Substance Use Disorder (SUD) Providers to report local complaints, appeals, and grievances related to dissatisfaction with services authorized and/or delivered by Mid-State Health Network's (MSHN) Provider Network. This is inclusive of services for people with a Mental Illness (MI), Intellectual Developmental Disability (IDD) and Substance Use Disorders (SUD). The data collected will be used by the Compliance Officer to review and monitor any trends or outliers and ensure all applicable guidelines are being followed.

MSHN delegates the responsibility for reporting the status of State Fair Hearings, including complaints, appeals, and grievances consistent with federal and state guidelines, to the CMHSP Participants/SUD Provider Network. MSHN will provide oversight and monitoring of the process. The Compliance Officer is responsible to address any concerns or trends where policy and/or protocol is not being followed.

Procedure

A. Medicaid Appeals/Grievances Report

1. Each report shall be submitted per the Appeals and Grievance Project Description Study (Exhibit 1)
2. Required reporting includes the following Indicators:
 - a. Indicator #1 Timeliness of Denials
 - b. Indicator # 2 Timeliness of Appeals
 - c. Indicator #3 Timeliness of Second Opinion (Applicable only to CMHSP Participant Services; not SUD Services)
 - d. Indicator #4 Timeliness of Response to Grievances
 - e. Indicator #5 Required Submission of Recipients Rights Semi-Annual and Annual Reports
3. The documentation shall be completed in its entirety prior to submission of report
4. The Medicaid Appeals and Grievances Report to MSHN is due and required to be submitted on the following dates:
 - a. June 30: October – March data
 - b. December 31: April - September data

B. Recipient Rights Report for Indicator #11

1. The Recipient Rights Report (Exhibit 3) to MSHN is due and required to be submitted on the following dates:
 - a. June 1: October – March (semi-annual report)
 - b. December 1: October – September (annual report)

C. Medicaid Fair Hearings Report

1. Each report shall be documented on the Medicaid Fair Hearings Report (Exhibit 2) 2. Required reporting includes:
 - a. Semi-annual;
 - b. PIHP or CMHSP Participant Name;
 - c. County;
 - d. Provider Name;
 - e. Number of Requests for Hearing During the Reporting Period;
 - f. Number of Hearings Held During the Reporting Period;
 - g. Number of Hearings Held During the Reporting Period that Resulted in Favor of Consumer;
 - h. Number of Hearings Held During the Reporting Period that Resulted in Favor of CMHSP Participant or PIHP;
 - i. Number of Orders of Dismissal Received from MAHS During the Reporting Period;
 - j. Number of Hearings Held During the Reporting Period Due to Suspension of Services;
 - k. Number of Hearings Held During the Reporting Period Due to Reduction of Services;
 - l. Number of Hearings Held During the Reporting Period Due to Termination of Services;
 - m. Number of Hearings Held During the Reporting Period Due to Denial of Services;
 - n. Number of Hearings Held During the Reporting Period Due to Admin. Discharge (Relevant to SUD); and
 - o. Total
3. The documentation shall be complete in its entirety prior to submission of report
4. The Medicaid Fair Hearings Report to MSHN is due and required to be submitted on the following dates:
 - a. January 31: April 1 – September 30 data
 - b. July 31: October 1 – March 31 data
5. Reporting shall be submitted to the Customer Service & Rights Specialist

Applies to:

- All Mid-State Health Network Staff Selected
 MSHN Staff, as follows:
 MSHN's Affiliates: Policy Only Policy and Procedure
 Other: Sub-contract Providers

Definitions:

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

- a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment for a service.
- d. 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.

- e. Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization.
- f. Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
- g. Failure of the PIHP to act within 30 calendar days from the date of a request for a standard appeal.
- h. Failure of the PIHP to act within 72 hours from the date of a request for an expedited appeal.
- i. Failure of the PIHP to provide disposition and notice of a local grievance/complaint within 90 calendar days of the date of the request.

Appeal: A review of an Adverse Benefit Determination

CMHSP: Community Mental Health Service Program

Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP to make an authorization decision.

Medicaid Services: Services provided to a beneficiary under the Medicaid State Plan, Healthy Michigan, Habilitation Services and Supports Waiver and/or 1915(b)(3) waiver of the Social Security Act

MSHN: Mid-State Health Network

PIHP: Pre-paid Inpatient Health Plan

State Fair Hearing: A state level review of beneficiaries' disagreements with CMHSP, or PIHP denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Health and Human Services perform the reviews.

SUD: Substance Use Disorders

SUD Provider Network: Refers to a SUD Provider that is directly under contract with the MSHN PIHP to provide services and/or supports

Other Related Materials:

- Exhibit 1: Appeals and Grievance Project Study
- Exhibit 2: Medicaid Fair Hearings Report Template
- Exhibit 3: Recipient Rights Report for Indicator #11 Template

References/Legal Authority:

The following federal and state statutes establish the standards for MSHN's Appeals and Grievance procedures for Medicaid Recipients:

1. 42 CFR 438.10: Information Requirements
2. 42 CFR 431.200 Fair Hearings
3. 42 CFR 438.400 Appeals and Grievances
4. Michigan Department of Community Health, Grievance and Appeal Technical Requirement, July, 2004.
5. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)
6. Michigan Mental Health Code (MHC) MCL 330.1705 (Medical Second Opinion)

Change Log:

Date of Change	Description of Change	Responsible Party
03.23.2015	New Procedure	A. Horgan
11.21.2016	Annual review, new reporting indicators and due dates	Customer Service Committee
12.18.17	Annual review, definitions updated	Customer Service Committee