NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY

Customer Service
and
Grievance & Appeals Training

What does Customer Service do?

- **For Recipients:**
  - Triage calls to the appropriate person/team
  - Troubleshoot
  - Provide information for community resources
  - Coordinate translators and independent facilitators
  - Also provides grievance and appeals support
- **For NLCMHA**
  - Quarterly reports to MDHHS, NMRE, and internal NLCMHA
  - Monthly discharge satisfaction surveys
  - Monthly credentialing reports for HR
  - Lobby monitor content (pre-COVID)
  - Tracks accommodations
  - Also the grievance and appeals coordinator

Customer Service and Accommodations

- **Interpreter**

  - Must be requested at least ***2 weeks*** in advance
  - Request goes through Customer Service, who will link you with the interpreter agency to coordinate date, time and location of meeting

- **Independent Facilitator**

  - Must be requested at least ***2 weeks*** in advance
  - Request goes through Customer Service, who will link you with the Independent Facilitator to coordinate a date, time, and location for meeting

Accommodation Examples

ALL ACCOMMODATIONS MUST BE REPORTED TO CUSTOMER SERVICE

Examples:

Language

- American Sign Language
- Foreign Language
- Visual and Hearing Impaired
- Comprehension (Reading and Writing)
- iPad Applications

Environmental

- Sensitivity to scents
- Operating Hours
- Mobility Issues
- Availability

Other

- Help finding/maintaining Employment
- Ride in personal or Agency vehicle
- Bus fare
- Location of meeting

GRIEVANCE AND APPEALS

Legalities of Grievance and Appeals

Medicaid Standards

- • 42 CFR (Code of Federal Regulations)
- • Medicaid Managed Specialty Supports & Services Concurrent 1915(b)/(c), Waiver Program Contract, Attachment P6.3.1.1 Grievance and Appeal Technical Requirement Attachment P4.4.1.1 Person Centered Planning Policy
- • Healthy Michigan contract
- • PIHP Grievance and Appeal Policy
- • NLCMHA Grievance and Appeal Policy 106.106

Non Medicaid Standards

- • Michigan Mental Health Code, Act 258 of the Public Acts of 1974
- • MDHHS/CMHSP Managed Mental Health Supports and Services Contract (a) Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process

  (b) Attachment C6.3.2.2 – CMHSP

  Family Support Subsidy Process
- • NLCMHA Grievance and Appeal Policy 106.106

Who qualifies for grievance and appeals?

- For purposes of Actions / Adverse Benefit Determination/ Notices / Appeals / Grievances, a person served who has any of the following, will answer this question with a "Yes".

- 1. Medicaid (sometimes referred to as "fee-for-service" or "traditional" Medicaid)
- 2. All Medicaid Health Plans (MHP - i.e. Meridian, Molina, etc.)
- 3. Healthy Michigan Plan (Expanded Medicaid)
- 4. Medicaid Deductible/Spend-down (must meet financial obligations first)
- 5. Michigan Medicaid Waiver Programs including: a. Habilitations Supports Waiver (HSW) b. Children's Waivers [does not include MI-Child]

Grievances Overview

What is a Grievance?

- expressions of dissatisfaction about any matter other than an recipient rights complaint.

- There are two types of grievances:
  - Change of Provider
  - Grievance Complaint

Who can file a Grievance?

- Person Served
- Guardian
- Parent

❖Providers are expected to assist with filing a grievance.

Grievance Overview (continued)

When Can a Grievance be Filed?

- At anytime. Grievances are not time limited.

What's the Process?

- A grievance can be accepted in writing or by telephone.
- The Grievance and Appeal Coordinator will send the grievance to the staff's supervisor for review and completion.

- The supervisor has up to 30 days to complete a Change of Provider grievance, and 90 days to complete the complaint grievance review.(60 for non-Medicaid)
- The G&A Coordinator must provide a Notice of Receipt within 5 business days of receiving the grievance to the recipient. At 90 days a Notice of Determination will be sent, which includes the findings.
- Any grievance that may be a Rights violation will be forwarded to the Office of Recipient Rights for investigation.

Adverse Benefit Determinations (ABD)

Service decisions are based on persons served meeting medical necessity criteria for community mental health service programs

Adequate Notice

- Denying a new service
- Denying inpatient hospitalization
- denying a change in service (i.e. amount, scope or duration).

Advance Notice

- Authorizing a change in service (i.e. amount, scope or duration)
- Reducing, suspending or terminating current services

IMPORTANT

ABD Timeframe Compliance

- **ADEQUATE NOTICE**

- This is sent the day the decision is made; the Notice Date and Effective Date are the same.

- **ADVANCE NOTICE**

- Provided to recipient before the change is set to take affect.

- Effective Date is 10 days after the Notice Date for Medicaid, and 30 days for non-Medicaid.

**The 10 days between the Notice Date and the Effective Date on Advance Notice, gives the recipient time to file an appeal before the effective date, which allows for their services to continue during the appeal process.

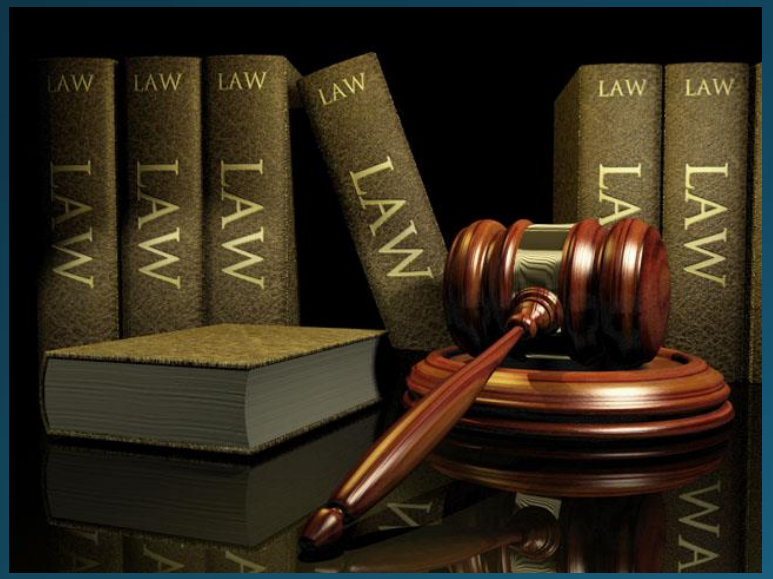
IMPORTANT ABD INFORMATION

Before the provider sends out an Advance Notice notifying a person served that their current service(s) will be terminated, they need to ensure that the NLCMHA medical records clearly document and identify why services are being terminated.

Some examples may include:

- ❑ Lack of medical necessity for the service as determined by an assessment of the person's needs by a qualified professional.
- ❑ Current institutional residence that prohibits NLCMHA authorization for services.
- ❑ The person served is not participating in services as authorized in their IPOS.
- ❑ The person served has not responded to outreach contacts.
- ❑ Attempts were made to assist with and encourage the person served to follow the goals and receive the services which they requested and were authorized.

The notice of Adverse Benefit Determination (Medicaid) must meet the following requirements:



- 1. Enrollee notice must be in writing, and must 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," meets the needs of those with limited English proficiency and or limited reading proficiency);
- 2. 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;
- 3. Description of Adverse Benefit Determination [the service decision made];
- 4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
- 5. 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);
- 6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;
- 7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
- 8. Notification of the 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 required when providing "Advance Notice of Adverse Benefit Determination");
- 9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and 10. An explanation that the enrollee may represent himself or use legal counsel, a relative, a friend or other spokesperson.

APPEAL PROCESS

As previously noted, ABDs are mandated documents, notifying persons served of their right to "appeal" an NLCMHA "action" or decision that will affect their current services or request for new or additional services.

Due Process: refers to legal protection or rights given to individuals under the law. Due process for persons served includes providing:

1) prior written notice of the Action

2) different levels of appeal before an impartial decision maker

3) continued benefits (Medicaid) pending a final decision

4) a timely decision

Local/Internal Appeal Process
(Medicaid)

- Persons served have 60 calendar days from the "Notice Date" to request a Medicaid Local Appeal.
- Requests for appeal should be written; however, oral requests for appeals will be accepted and will act as the date the appeal request is officially received.
- Appeals are coordinated by the Grievance and Appeal Coordinator in the Customer Services Office.
- NLCMHA has 30 calendar days from the date the local appeal request was received to provide the person served with a written Notice of Local/Internal Appeal Resolution.
- Requests for expedited appeals will be honored if waiting for a standard time would seriously jeopardize the person's life or ability to attain, maintain or regain maximum function. Expedited appeals, if approved, must be resolved within 72 business hours.

State Fair Hearing Appeal Process
(Medicaid)

- Persons served with Medicaid have the right to request a Fair Hearing only after utilizing the Internal Appeal process first and the appeal review determined to uphold the decision.

- Persons served can ask for a fair hearing within 120 calendar days from the date of the NLCMHA Notice of Internal Appeal Resolution.

- The NLCMHA Fair Hearing Officer will create a Hearing Summary to submit to the Administrative Tribunal/Administrative Law Judge and to the person served prior to the Hearing.

- The Hearing Summary is based primarily on documentation in the person's NLCMHA medical record.

- Providers may be asked to attend hearings to provide oral testimony.

- Fair Hearings are also referred to as Administrative Hearings and are handled by the Michigan Office of Administrative Hearings & Rules (MOAHR).

Local Dispute Resolution Process

(Non-Medicaid)

- This resolution process is provided for persons served without Medicaid
- The persons served must ask for a Local Dispute Resolution before they can request a state level resolution from MDHHS
- A person served must request a Local Appeal Resolution within 30 days of the notice provided
- Requests for appeal should be written; however, oral requests for appeals will be accepted and will act as the date the appeal request is officially received.
- As with Medicaid appeals, the appropriate management staff will assign a qualified staff person to provide the Non-Medicaid local appeal review, who
    1. has the appropriate clinical expertise, and
    2. was not part of the original decision process
- NLCMHA has 45 days to provide a written response/resolution to the person served based on the findings of the staff doing the Local Dispute resolution.

State Dispute Resolution Process
(Non-Medicaid)

- Persons served without Medicaid have the right to request a state level dispute resolution only after utilizing the local dispute resolution process and the resolution determined to uphold the decision.

- Non-Medicaid recipients can ask for a fair hearing within 10 calendar days from the date of the NLCMHA Notice of Local Dispute Resolution.

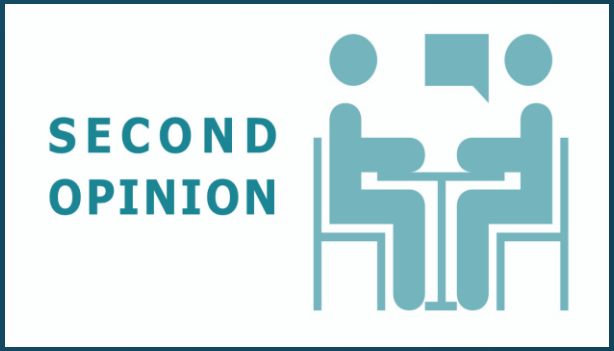
- Persons served must make a written request to MDHHS. Instructions on how to access this level of appeal is included on the Non-Medicaid Notices.

Family Support Subsidy

Recipients (Medicaid or Non-Medicaid) of the Family Support Subsidy (FSS) can use the NLCMHA Local Appeal process to appeal FSS decisions (i.e. denial, payback requests, and termination of FSS)

1. Requests must be received within two months (60 calendar days) of the date on the NLCMHA notification letter.
2. The NLCMHA Family Support Subsidy Coordinator notifies the Grievance and Appeal Coordinator when a family requests a local appeal.
3. The FSS is only appealable through the local appeal process through NLCMHA. FSS Recipients can go to the Circuit Court in their county of residence if they are not satisfied with the local appeal resolution decision.

SECOND OPINION



Access to Services

- Offered orally and in writing at the time of denial of an applicant's initial request for CMH services
- 2nd Opinion provided within 5 days of the denial
- Completed by a qualified person other than the person who originally denied services

Inpatient Hospitalization

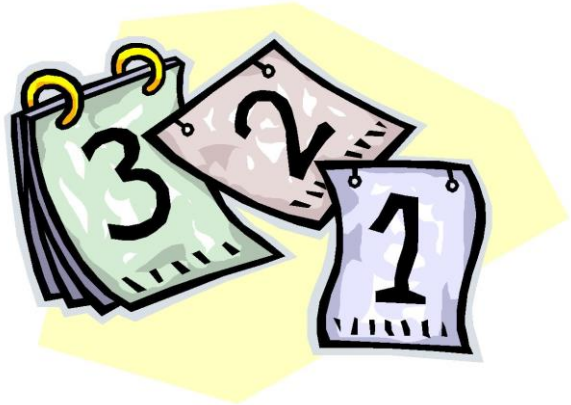
- Offered orally and in writing at the time of denial of request for in-patient hospitalization
- 2nd Opinion provided within 72 hours
- Most second opinions for inpatient (hospitalization) service denials are provided by the NLCMHA Medical Director

FOR ALL SECOND OPINIONS:
The decision must be provided both orally and in writing to the person served and must be documented and placed in the person's medical record.

REQUEST FOR EXPEDITED SECOND OPINION

- Requests for expedited reviews will be approved and completed IF it is determined that the standard time for resolution could seriously jeopardize the individual's life health or safety, or ability to attain, maintain or regain maximum function.

- Access/Services: expedited review within 3 business days
- Inpatient Hospitalization: expedited review within 24 hours



MEDIATION REQUESTS/PROCESS
MENTAL HEALTH CODE Public Act 258 of 1974, updated 2020

- A client of [NLCMHA] has the right to request mediation with [NLCMHA] related to the client's behavioral health service, planning, and supports.
- [NLCMHA] is required to share with the client the client's right to mediation when the client receives services and then annually after that. CMH is also required to share the client's right to mediation when the community mental health services program's or service provider's local dispute resolution process, local appeals process, or state Medicaid fair hearing is requested.
- MDHHS is required to contract with a service provider.

MEDIATION REQUESTS/PROCESS CONT'D

MENTAL HEALTH CODE Public Act 258 of 1974, updated 2020

Mediator must be:

a. Trained in effective mediation technique and mediator standard of conduct,
b. b. Knowledgeable in laws, regulations, and administrative practices relating to behavioral health services and supports.
c. Neutral.

5. If mediation is requested, CMH or PIHP must participate.

6. Quest for mediation must be recorded by a mediation organization.

a. A mediation must begin within 10 business days after the recording.
b. The CMH client can also use other dispute resolution processes, such as: the community mental health services program's local dispute resolution process, the local appeals process, the state Medicaid fair hearing, or filing a recipient rights complaint.

i. A mediation organization must ask if another dispute resolution process is ongoing and notify the process administrator of the request for mediation.
ii. The parties can voluntarily suspend the other dispute resolution process, unless prohibited by law or precluded by a report of an apparent or suspected violation of rights delineated in chapter 7.

MEDIATION REQUESTS/PROCESS CONT'D
MENTAL HEALTH CODE Public Act 258 of 1974, updated 2020

7. Mediation must be completed within 30 days after the date the mediation was recorded unless the parties agree in writing to extend the mediation period for up to an additional 30 days. The mediation process must not exceed 60 days.

"Recording" means a file that has been created after a request for mediation has been made by a recipient or his or her individual representative or received by a community mental health services program or other service provider under contract with the community mental health services program. (Section 11)

8. If the dispute is resolved through mediation, the mediator must create a legal binding document that includes the terms of the agreement.

a. The document must be signed by the client or individual or their representative and a party with authority to bind the service provider according to the terms of the agreement.

b. b. A copy of the signed agreement must be provided to all parties within 10 business days after the end of the mediation.

c. The signed document is enforceable in any court of competent jurisdiction in this state.

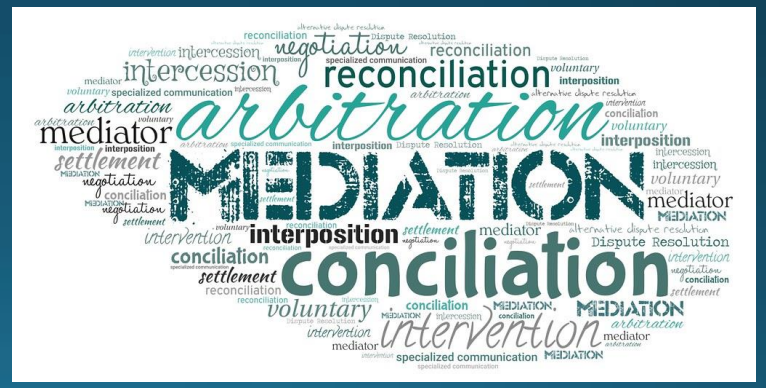
What can be mediated?

Mediation CANNOT mediate

- Assisted Outpatient Treatment Plans
- Recipient Rights Investigations
- Medical Necessity
- Medicaid Fair Hearings
- The role of CMH staff as experts

Mediation CAN mediate

- Community mental health services program; purpose; services.



*** Please note Mediation is NOT part of the local appeals process.**

- NLCMHA client/consumer must call OMC at 844-3-MEDIATE to initiate a case and have it covered by the grant. (no fee)
- OMC Mediation Specialist will do initial intake.
- OMC Mediation Specialist will refer the case to the appropriate CDRP within 2 business days.
- CDRP will conduct the full intake and schedule the mediation session within 10 business days.

Northern Lakes CMHA Customer Service Specialist/Grievance and Appeals Coordinator

- Brie Molaison
- Brie.Molaison@nlcmh.org
- 231.876.3246

or

800.337.8598