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Region 10 Board</td></tr>
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I. APPLICATION:

☒ PIHP Board ☒ CMH Providers ☐ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It is the policy of Region 10 PIHP to follow all state and federal regulations regarding the resolution of complaints and disputes individuals may have about their services and supports managed and/or delivered by the PIHP, CMH and its provider network. This policy is for consumers receiving mental health services from PIHP/CMH. For SUD service related issues refer to SUD Grievance policy 07-03-02.

This policy is for the purpose of establishing a local process for resolving grievances and complaints that are not related to an action, or a Recipient Rights Violation complaint, as there are separate processes.

This is a delegated function to the partner CMHs.

III. DEFINITIONS:

Access: The initial point of contact for applicants to request mental health and substance use disorder services and supports.

Action: A decision that adversely impacts a beneficiary's claim for services due to:

A. Denial or limited authorization of a requested service, including the type or level of service.
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 provide service within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by Region 10.
F. Failure of the PIHP to act within 45 calendar days from the date of a request for a standard appeal.
G. Failure of the PIHP to act within three working days from the date of a request for an expedited appeal.
H. Failure of the PIHP/CMH to provide disposition and notice of a grievance/complaint within 60 calendar days of the date of the request.

*The authorization of services as identified in the Individual Plan of Service is also considered an action.

Appeal: A request for review of an action, as "action" is defined above.

Applicant: A person or his/her legal representative who makes a request for mental health services.

Beneficiary: An individual who has been determined eligible for Medicaid.

Disposition: Written statement of the decision of an appeal or a grievance, provided to the beneficiary.

Grievance system: The federal term used to refer to the overall system that includes grievances and appeals handled at the PIHP level and access to the State fair hearing process.

Grievance: An expression of dissatisfaction about any matter other than an action, as "action" is defined above.

Local Appeal Process: Impartial review of a Medicaid' beneficiary's appeal for an action presided over by individuals not involved with decision-making or previous level of review, completed by the PIHP.

Mental Health Professional: A person who is trained and experienced in the area of mental illness or developmental disabilities, as identified per MDHHS staff qualification criteria.

MDHHS: Michigan Department Health and Human Services.

Recipient Rights Complaint: Written or verbal statement by a person receiving services, or anyone acting on behalf of the person recipient services alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved thought processes established in Chapter 7a.

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

IV. STANDARDS:

A. Consumers of mental health services or applicants of, have the right to file a complaint or grievance regarding mental health services.
B. A grievance may be filed at any time, there are no time limits.
C. A grievance may be filed by the consumer, guardian, parent of minor child or legal representative, or provider with written permission from the consumer indicating the wish to file a grievance.
D. A consumer may file a grievance orally or in writing.
E. Consumers will be given assistance from staff in the filing process, including but not limited to, interpreter services, explanation of process or completing forms, if needed.
F. Toll free numbers will be available to consumers to file a grievance, once established.
G. Each CMH will designate at least one staff person to be responsible for facilitating the resolution of the grievance. That designee will:
    1. Acknowledge and log each grievance received.
    2. Ensure the individual(s) who make decision on grievances are individuals:
        a) Who are not involved in any previous level of review or decision making
        b) Who are health care professionals who have the appropriate clinical expertise, in treating the enrollees condition or disease:
            1. A grievance regarding the denial of expedited resolution of an appeal
            2. A grievance that involves clinical issues.
H. Consumers do not have access to the fair hearing process unless the CMH fails to respond to the grievance within 60 calendar days of receipt of the grievance.
I. Grievances must be resolved within 60 calendar days of the date of recipient of the grievance.
J. For each grievance filed, a written disposition will be generated that will include the results of the resolution process and the date it was completed. For grievances not completed within the required timeframe, the disposition will also include the rights and instructions to a fair hearing, for Medicaid Beneficiaries only.

V. PROCEDURES:

Consumer responsibility:
Submits a grievance either orally or in writing to the PIHP designee or CMH customer services representative.

CMH Designated Staff responsibilities:

A. Acknowledges the receipt of grievance by using the EMR opening letter.
B. Determine if grievance is a Recipient Rights complaint or an appeal, refer to appropriate office of jurisdiction for processing.
C. Completes all necessary tasks to investigate and take action to resolve the grievance.
    a. Staff processing grievance will not be staff involved with original complaint.
    b. Staff shall have appropriate authority to require corrective action if needed.
    c. Grievances involving clinical issues, or regarding the denial of an expedited appeal, shall be processed by a health care professional, with appropriate clinical expertise.
D. Upon resolution of grievances, completes disposition (closing letter) in EMR. Mail to consumer.
    a. Closing letter will include the date completed, the resolution, steps taken to resolution, and if outside timeframe required for completing the grievance, the rights and instructions for requesting a fair hearing, for Medicaid beneficiaries.
E. All grievances must be resolved within 60 calendar days of receipt of the grievance.
F. All grievances will be logged, documented and recorded in the "Grievance Module" in EMR.

PIHP responsibilities:

A. Monitor grievance process, ensure requirements are met.
B. Monitor trending issue and report to appropriate authority.
C. Report to QI Committee on a quarterly basis.
D. Report to PIHP Board of Directors upon request.

VI. EXHIBITS:
Grievance Flow Chart

VII. REFERENCES:
42 CFR 438 et. al.
MDHHS/PIHP Contract Attachment 6.3.2.1
MDHHS/CMHSP Contract Attachment 6.3.2.1
MI Mental Health Code