

<b>COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN</b>	<b><i>Policy and Procedure</i></b>		
<b>Department Member Services</b>	<b># of Pages: 13</b>		
<b>Policy Name REGIONAL MEMBER SERVICES POLICY</b>	<b>Type of Policy:</b> <input type="checkbox"/> WCHO <input checked="" type="checkbox"/> Regional <input type="checkbox"/> Network		
<b>Policy Number</b>	<b>Effective Date 12/16/05</b>	<b>Revision Date</b>	<b>Approval Date  2/8/06</b>
<b>Administrative/Board of Directors Sign Off</b>			
<b>Administrative Signature:</b>		<b>Date:</b>	
<b>Board of Directors Signature:</b>		<b>Date:</b>	

## I. PURPOSE

To establish policy and procedures for the provision of Member Services in a way that ensures consumer satisfaction with services and enhances the relationship between consumers and their community. The focus of Member Services includes problem prevention and the resolution of grievances, and promoting consumers' voices are heard respected, and included in organizational decisions and service provision.

## II. APPLICATION

This policy applies to the Prepaid Inpatient Health Plan (PIHP) and the Comprehensive Specialty Services Programs (CSSN's).

All Community Mental Health of Southeast Michigan affiliation partners, all WCHO staff, students and volunteers, and those of organizations under contract with WCHO, subcontracted providers and substance abuse agencies under contract with the WCHO.

## III. DEFINITIONS

Consumer – An individual who is receiving CMH or Substance Abuse services, including services provided by substance abuse agencies under contract with the WCHO

Comprehensive Specialty Services Network CSSN - An organization that is certified as a CMHSP, including a recipient rights systems, services across all populations, has a publicly appointed Board of Directors, and has accreditation from JCAHO.

Expedited Appeal – The prompt review of an action, requested by a consumer/legal representative or a provider on behalf of the consumer, when the time necessary for the

normal/standard review process could seriously jeopardize the consumer's life or health to attain, maintain or regain maximum function. If the consumer/legal representative requests the expedited review, the WCHO/affiliate determines if the request is warranted. If the consumer's provider makes the request, or supports the consumer's request, the WCHO/affiliate must grant the request. If a request made solely by consumer/legal representative is denied, the consumer/legal representative may file a grievance.

Grievance –An expression of dissatisfaction about any matter related to services, other than an adverse action, which does not involve a rights complaint. 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 consumer.

Inquiry – a contact made to the member services department (via phone, mail, e-mail or in person) from consumers, legal representatives, family members, providers, or anyone in the community seeking information and assistance. Inquiries can include (but are not limited to): information on benefits, services, providers, transportation, and reasonable accommodations available to consumers.

Legal Representative – The guardian, parent of a minor, or other person authorized by law to represent a consumer.

Member Services (also known as customer services) – The department that provides a link between consumers, their service network, and their community. The department responds to any inquiries made by consumers/potential consumers/family members/the community, and responds to grievances made by consumers/legal representatives. Member Services staff orient consumers to the Service Network, provide information on benefits and availability of services, and assists consumers in pursuing services as needed.

Pre-paid Inpatient Health Plan (PIHP) - The organization that manages specialty health care services under the Michigan Medicaid Waiver Program for Specialty Services. The PIHP provides specialty health care services to enrollees under contract with the state, and on the basis of prepaid capitation payments or other payments that do not use State plan payment rates. The PIHP provides, arranges for, or otherwise has the responsibility for the provision of hospital or institutional services for its enrollees, and does not have a comprehensive risk contract.

Rights Complaint – A written or verbal statement by a consumer or anyone acting on behalf of a consumer alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Network – The group of providers with which the CMHPSM contracts or makes arrangements to furnish specialty support services to consumers through the CMHPSM network panel.

#### IV. POLICY

Member Services is a set of functions that interacts with all other aspects of business within the PIHP and the CSSN's. Member Services operates to enhance the relationship between the community and the consumer, and the consumer and the individual. It is the responsibility of Member Services to ensure that the community mental health system provides care that is respectful, is available to all consumers, and is free of stigma. To achieve this, Member Services must therefore interact with all other aspects of organization operations and operate in a way that ensures the dignity and privacy of applicants/consumers.

In order to achieve these goals, Member Services shall:

- A. Orient new individuals to the services and benefits available to them, including how to access services, also any fees and co-pays they are responsible for.
- B. Provide consumers with information on provider network, accessing services, and service authorization, including providers who are accepting new consumers.
- C. Provide consumers with information on the recipient rights protection processes and how to file a rights complaint.
- D. Provide consumers with information on other rights they are entitled to, including their freedom to exercise those rights without retaliation, harassment, or discrimination.
- E. Help consumers/applicants with problems and inquiries regarding benefits.
- F. Oversee and assist consumers/legal representatives with the grievance process, including assuring the grievance process is conducted in a timely manner in accordance with the Balanced Budget Act requirements and the Regional Grievance and Appeals policy.
- G. Assure translator services will be provided to consumers/potential consumers in accordance with the WCHO Interpreters for Persons with a Hearing Impairment policy or the regional Limited English Proficiency policy at no charge to the consumer/legal representative.
- H. Notify consumers of, and assure that written information is available in alternative formats and in an appropriate manner that considers special needs. Assures that available resources include oral interpretation services; that written information is available in prevalent languages; and that such services will be free of charge to the consumer. Assures consumers are given an explanation of how to access these services or information.
- I. Assure that all notices and written communication provided to applicants/consumer are available in a manner and format that is easily understood, including large print when needed.
- J. Address needs or barriers related to cultural sensitivity, reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communication.

- K. Track and report trends and problem areas to the organization both locally and regionally.
- L. Provide a system of service that is readily available and quickly assists consumers.
- M. Address the need for cultural sensitivity and reasonable accommodation for persons with physical disabilities, hearing and/or visual impairments.
- N. Track the effectiveness and efficiency of Member Services functions through documented and periodic reports that show performance.
- O. Assist consumers and family members to find mechanisms within the CMHPSM to provide their voice, input and insight into the operation of the CMHPSM. This includes soliciting membership on advisory councils, performance improvement activities, development of new service programs, community awareness outreach initiatives, providing or facilitating arrangement for advocacy when requested, mentoring, developing informational material, newsletters and customer satisfaction inquiries.
- P. Maintain and make available to applicants/consumers/legal representatives written information on benefits, access to services, services available, service authorization, provider network information, the grievance system, and Member Services functions. This shall include annual review and revision of this information.
- Q. Assure applicants/consumers are provided with the information described above at the time they enter services, and are informed of their right to request and obtain this information at least once a year, in accordance with the Balanced Budget Act.
- R. Be available to the consumers during normal business hours and assist the consumer on the first contact.
- S. Clearly identify hours of operation.
- T. Assure facilitation of phone access from the consumer, legal representatives, the community and service providers throughout normal business hours (voice mail and answering machines are not considered phone access).
- U. Enhance the relationship between the agency and the community.
- V. Ensures that consumers are notified of any significant changes within 30 days before the intended effective date of the change.
- W. Assure consumers are notified within 14 days of when provider services have been terminated or when a provider terminates their contract; notification will be given to those consumers who are receiving services from said provider.

- X. Assures that written notice will be provided to consumers and guardians as applicable when a contracted provider's services are terminated for whatever reason.
- Y. Assist individuals in accessing transportation services needed for medically-necessary services; including specialty services identified by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
- Z. Inform consumers of any significant changes in providers or benefits

Member Services shall coordinate efforts locally with the Recipient Rights Office to assure that ORR is informed of potential rights violations, and Member Services is informed of grievances in the course of daily operations.

Member Service staff shall be knowledgeable regarding different methods used per population served for orienting consumers into the general community based on the eligibility criteria and availability of services offered through the network.

Member Service staff shall have up-to-date knowledge regarding benefits, the provider network, applicant and network policies/procedures regarding access, service authorization, and grievance/appeal procedures and are skilled in customer relations. Member Services staff shall be trained on this information at the time of hire and received refresher training therein annually.

Member Services staff shall assure compliance with any applicable Federal or State laws that pertain to consumer's informational rights, and ensure that information is disseminated through the region on how staff and subcontract providers need to include those rights in the provision of services to consumers. The Regional Member Services Committee shall review any areas of needs with applicable state and Federal laws on a regular basis, and report these needs and any recommendations to the Regional Performance Improvement Committee and/or Regional Corporate Compliance Committee when needed.

## **V. EXHIBITS**

- A. Grievance Process Instructions for Affiliation Staff
- B. CMHPSM Grievance Report/Inquiry Form

## **VI. REFERENCES**

- A. Balanced Budget Act (specifically 42CFR438.100 and 42CFR 438.10)
- B. Regional Consumer Grievances and Appeals Policy
- C. Regional Limited English Proficiency Policy
- D. HIPAA
- E. MDCH PIHP Medicaid Contract
- F. MDCH PIHP General Funds Contract
- G. MDCH CMHA Medicaid Contract
- H. MDCH CMHA General funds Contract

## VII. PROCEDURES

### A. Grievances

The grievance process is for any expression of dissatisfaction with service provision that is *not* related to an adverse action and is *not* a Rights complaint. A grievance may be filed by a consumer or the consumer's legal representative. If the consumer requires assistance in filing a grievance, the Member Services or Office of Recipient Rights will assist as needed. Grievances may be filed orally or in writing.

<u>WHO</u>	<u>DOES WHAT</u>
Consumer or Legal Representative	<ol style="list-style-type: none"><li>1. Files a grievance orally or in writing</li></ol>
Local Member Services Staff	<ol style="list-style-type: none"><li>1. Logs receipt of grievance and enter relevant information on grievance report form.</li><li>2. Consults with the Office of Recipient Rights to determine if the grievance is a legally protected right. If so, informs person filing grievance of the need to refer the matter to ORR; refers to the local Office of Recipient Rights for follow-up, and logs ORR referral on grievance report form.</li><li>3. Sends written acknowledgement of receipt of the grievance within 5 days and explains the process. Contacts the consumer/legal representative by phone if needed to review the grievance.</li><li>4. Submits the grievance and grievance report form to the appropriate staff, including an administrator with the authority to require corrective action, and who was not involved in the initial determination that led to the grievance.</li><li>5. Any grievances that Member Services staff have the authority to respond to will be signed of by the Member Services supervisor prior to the disposition notification being sent to the consumer.</li></ol>
Local Assigned Administrator or Member Services Staff	<ol style="list-style-type: none"><li>1. Takes necessary action to assure the grievance is resolved, and corrective action is taken when necessary.</li><li>2. If the grievance involves clinical issues or issues of medical necessity, assures professional(s) who have the appropriate clinical expertise in treating the consumer's condition are involved in review of the grievance.</li><li>3. Assures the grievance is disposed of within 10 calendar days wherever possible. The disposition will not necessarily be in favor of the consumer, but the grievance must be addressed within required time frames.</li><li>4. Assures the consumer receives written notification of the disposition</li></ol>

within the required timeframes.

5. Ensures the grievance report form is completed and signs form.
6. If the grievance is not disposed of within 60 calendar days, notifies the consumer/legal representative of applicable appeal rights on the 61<sup>st</sup> day.
7. Provides quarterly summary data to the Regional Member Services Committee to the local Board's QI/PI program.

Office of Recipient  
Rights Staff

1. When providing consultation to Member Services, or when triaging a call to the ORR, makes the final determination whether:
  - a. A received rights complaint involves a grievance.
  - b. A grievance involves a legally protected right.
2. Follows ORR procedures for a rights complaint when ORR staff determines that a grievance also involves a legally protected right.
3. Refers any grievance portion of rights complaint to local Member Services department.

Regional Member  
Services Committee

1. Maintains grievance report database regionally.
2. Reviews data on a quarterly basis and reports regional summary of grievance data to the Regional Performance Improvement Committee and the Regional Due Process Committee.
3. Identifies any trends from grievance data and makes recommendations to the Regional PI Committee where needed.

## **B. Inquiries**

### **WHO**

Consumer, Legal  
Representative, Family  
Member, Provider, or  
other Community  
Member

### **DOES WHAT**

Local Member  
Services Staff

1. Contacts Member Services for information or assistance.
1. Takes contact (including inquiries and suggestions).
2. Logs receipt of inquiry on inquiry data form.
3. Consults with ORR as needed to clarify whether an inquiry may be a legally protected right or a grievance. If ORR determines the contact is a potential rights issue, refers to ORR and logs on inquiry form. If a grievance, follows the grievance procedure above.
4. Determines if contact is a suggestion that would be relevant feedback to provide to the WCHO via the Regional PI Committee.
5. Provides information or assistance as requested. Refers contact person to other resources where appropriate.
6. Ensures the inquiry data form is completed.
7. Maintains local inquiry database.

Regional Member  
Services Committee

8. Reports local data, including relevant suggestions to Regional Member Services Committee.
1. Maintains inquiry grievance report database regionally.
2. Reviews data on a quarterly basis and reports regional summary of inquiry data to the Regional Performance Improvement Committee.
3. Identifies any trends from inquiry data, including relevant suggestions, and makes recommendations to the Regional PI Committee where needed.

**GRIEVANCE PROCESS  
INSTRUCTIONS FOR AFFILIATION STAFF**

1. The purpose of the grievance process is to resolve grievances (defined as a dissatisfaction with services that is not related to an action and is not a legally protected right) as efficiently and quickly as possible.
2. Grievances will be handled at the local level. Grievances will be taken by the local Member Services department.
3. When a grievance is received by Member Services, orally or in writing, staff receiving the grievance will fill out the relevant portions of the Grievance Report form (see Exhibit P) and send an acknowledgment letter within 5 days. If the grievance can also be resolved within 5 days, the acknowledgment letter may also serve as the notice of disposition letter.
4. Member Services staff forwards the grievance to the assigned local administrator with the authority to require corrective action, and who was not involved in the grievance, and documents this information on the Grievance Report form in the “notification” area of the form.
5. If the local administrator determines that the grievance can be resolved by Member Services, the local administrator notes this on in the “notification” area of the Grievance Report form. Any grievances that Member Service staff have the authority to respond to will be signed of by the Member Services supervisor prior to the disposition letter being sent to the consumer.
6. The local administrator reviews the grievance and takes any necessary action to assure resolution of the grievance. If there are any clinical issues or matters of medical necessity, the local administrator assures that professional(s) with the appropriate clinical expertise are involved in review/resolution of the grievance. When professional(s) are involved, this information shall be noted in the “notification” area of the Grievance Report form.
7. Member Services shall maintain the grievance database. The Local G&A Administrator shall provide a quarterly data report this data to the Regional Fair Hearings Officer.
8. The Consumer/legal representative shall receive written notification of the disposition of his/her grievance. The CMHPSM seeks to send this written notification of the disposition within 10 calendar days. If the grievance is not disposed of within 60 calendar days, this constitutes an action, and on the 61st day the consumer/legal representative shall be given relevant information on their appeal rights, based on whether they are Medicaid or Non-Medicaid consumers.
9. If a local Director or Program Administrator receives a grievance (either directly or through the local Board) and he/she decides to handle the grievance rather than refer the grievance to Member Services, the affiliate Director/Program Administrator shall assure that grievance policies/procedures are followed per this policy, and document any other staff involved or referred to handle/resolve the

grievance in the “notification” area(s) of the Grievance Report form. Once the grievance case is completed, the Director/Program Administrator shall send the case file to Member Services.

10. Any cases not handled by the Member Services department shall be transferred to Member Services for filing. Upon receiving these files, Member Services staff will complete the “Case Closed” portion of the form and note their initials.

11. Any grievances that include a legally protected right will be referred to the local Office of Recipient Rights within 24 hours or one business day.

12. Any rights complaints received by the Office of Recipient Rights that meets the definition of a grievance shall be referred to the local Member Services department.

Grievance Report/Inquiry Form  
 Community Mental Partnership of Southeastern Michigan

EXHIBIT B

<b>Date Received:</b>		<b>How Received:</b>	(in person, phone, letter, survey, ORR, other)		
<b>Caller Name</b>		<b>Caller Telephone number</b>		<b>Relation to Consumer</b>	
<b>Consumer Name</b>		<b>Consumer Telephone</b>		<b>Consumer Address</b>	
<b>Case Number:</b>		<input type="checkbox"/> Medicaid		<input type="checkbox"/> Non-Medicaid	
<input type="checkbox"/> Grievance		<input type="checkbox"/> Inquiry	<input type="checkbox"/> MH	<input type="checkbox"/> DD	<input type="checkbox"/> SA
<b>Service in question</b>				<b>Provider Name</b>	
<b>Concern Type:</b> <input type="checkbox"/> Services & Supports <input type="checkbox"/> Environment <input type="checkbox"/> Staff-Related				<b>Issue (event, consumer wants, who was involved, etc.):</b>	
<input type="checkbox"/> Benefits <input type="checkbox"/> Billing/Financial <input type="checkbox"/> Other(Specify) _____					

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<b>1<sup>st</sup> notification of administrator or clinician</b>			
<b>Date/Time</b>		<b>Phone number</b>	
<b>Name/Title of staff</b>		<b>Response date/time</b>	
<b>2<sup>nd</sup> Notification of administrator or clinician</b>			
<b>Date/Time</b>		<b>Phone Number</b>	
<b>Name/Title of Staff</b>		<b>Response date/time</b>	
<b>3<sup>rd</sup> Notification of administrator or clinician</b>			
<b>Date/Time</b>		<b>Phone Number</b>	
<b>Name/Title of Staff</b>		<b>Response date/time</b>	
<b>Outcome:</b>			

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Closing Letter sent/date: \_\_\_\_\_  Sent to ORR/date: \_\_\_\_\_

Entered into data/date: \_\_\_\_\_

<b>Reviewer Signature:</b>		<b>Date:</b>		<b>Closing Date/MS staff Initials</b>
<b>Reviewer Signature:</b>		<b>Date:</b>		

