NORTHERN MICHIGAN REGIONAL ENTITY
GRIEVANCE AND APPEAL, FAIR HEARING PROTOCOL
PROTOCOL#: 07-03-001

I. PURPOSE AND BACKGROUND

This protocol is intended to facilitate compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part II, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Community Health (DCH). These requirements are applicable to all Northern Michigan Regional Entity providers, including affiliated Community Mental Health Services Programs (CMHSPs), the Substance Abuse Coordinating Agencies (CAs), psychiatric inpatient facilities and all contracted providers.

Although this protocol specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal**. Any other type of complaint is considered a **grievance**

The due process provisions of the U.S. Constitution guarantee that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the "Code") Chapters 7, 7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)

- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Protocol.

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

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- 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.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- 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/CMHSP.
- Failure of the PIHP/CMHSP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP/CMHSP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP/CMHSP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as "**B3**" waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested**. Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided / mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an "action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP/CMHSP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action**. 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 beneficiary

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action**.

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

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

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act

Notice of Disposition: Written statement of the PIHP/CMHSP decision for each local appeal and/or grievance, provided to the beneficiary.

PIHP: Prepaid Inpatient Health Plan. The Northern Michigan Regional Entity is the Medicaid prepaid inpatient health plan for an affiliation of five community mental health boards (CMHSPs). These CMHSP include: AuSable Valley Community Mental Health (AVCMH), Centra Wellness Network (CWN), North Country Community Mental Health (NCCMH), Northern Lakes Community Mental Health (NLCMH) and Northeast Michigan Community Mental Health (NeMCMH). When used in to assign responsibility in this document, PIHP refers to either the PIHP or the CMHSP or Substance Abuse Coordinating Agency (CA) to which the function is delegated.

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the 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.

III. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Compliant with federal regulation (42 CFR 438.228), the Northern Michigan Regional Entity, as the prepaid inpatient health plan (PIHP), has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438. This grievance system includes those PIHP functions performed by the CMHSP or CA as delegated via written agreements consistent with 42 CFR 438.230.

The grievance system provides Medicaid beneficiaries:

- A local PIHP/CMHSP appeal process for challenging an "action" taken by the PIHP/CMHSP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP/CMHSP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an "action".
- The right to **concurrently** file a PIHP/CMHSP level appeal of an action**, and** request a State fair hearing on an action, **and** file a PIHP/CMHSP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP/CMHSP level appeal of an "action".
- The right to request, and have, Medicaid benefits continued while a local PIHP/CMHSP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP/CMHSP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the beneficiary's behalf with the beneficiary's written consent to do so.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP/CMHSP **must provide** the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization**: Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for services.

  If the beneficiary or provider requests an extension **OR** if the PIHP/CMHSP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP/CMHSP may extend the **14 calendar** day time period by up to **14 additional calendar days**.

- **Expedited authorization:** In cases in which a provider indicates, or the PIHP/CMHSP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP/CMHSP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

  If the beneficiary requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP/CMHSP may extend the three (3) working day time period by up to **14 calendar days**

  When a **standard or expedited** authorization of services decision is extended, the PIHP/CMHSP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP/CMHSP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an **"action"** by authorizing a service in amount, duration or scope less than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP/CMHSP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP/CMHSP has taken, or intends to take and the process available to appeal the decision.

PIHP/CMHSP Notice of Action requirements include:

- The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).
- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP/CMHSP 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.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP/CMHSP must reinstate the Medicaid services until disposition of the appeal
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP/CMHSP must reinstate services to the level before the action
- **If** the utilization review function is not performed within an identified organization, program or unit (access center~~s~~, prior authorization unit, or continued stay unit~~s~~), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, **and requires** a written notice of action.

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary **at the time of EACH** action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.

- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

- What action the PIHP/CMHSP has taken or intends to take,
- The reason(s) for the action,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP/CMHSP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman,

The content of an advance notice must also include an explanation of:

- The circumstances under which services will be continued pending resolution of the appeal,
- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

There are limited exceptions to the advance notice requirement. The PIHP/CMHSP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP/CMHSP has factual information confirming the death of the beneficiary.
- The PIHP/CMHSP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns PIHP/CMHSP mail directed to him/her indicating no forwarding address.
- The PIHP/CMHSP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days**.

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP/CMHSP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days**.

If the PIHP/CMHSP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP/CMHSP **must** continue Medicaid services previously authorized while the PIHP/CMHSP appeal and/or State fair hearing are pending **if:**

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the PIHP/CMHSP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar** days pass after the PIHP/CMHSP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary.
- The time period or service limits of the previously authorized service has been met.

If the PIHP/CMHSP, or the DCH fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP/CMHSP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP/CMHSP, 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, the PIHP/CMHSP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP/CMHSP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days**. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The PIHP/CMHSP must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
- The PIHP/CMHSP may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP/CMHSP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP/CMHSP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP/CMHSP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- Expedited hearings are available.

Detailed information and instructions for the Fair Hearing process can be found in the DCH Administrative Tribunal Policy and Procedures Manual online at:
www.michigan.gov/documents/Manual_9658_7.pdf

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP/CMHSP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
- The beneficiary may file an appeal with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than **12 calendar days** from the date of the notice of action, the PIHP/CMHSP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP/CMHSP is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
- Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program.
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues
- Provide the beneficiary, or representative with:

    - Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
    - Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
    - Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
    - Information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP/CMHSP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution.
- The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:

- The right to request a state fair hearing, and how to do so;
- The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP/CMHSP mailing the notice of disposition, and how to make the request; and
- That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP/CMHSP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP/CMHSP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP/CMHSP receives the appeal.

- **Expedited Resolution**: The PIHP/CMHSP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working** days after the PIHP/CMHSP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP/CMHSP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

- The PIHP/CMHSP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.

- If the PIHP/CMHSP denies a request for expedited resolution of an appeal, it must:

  - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP/CMHSP receives the appeal;
  - Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
  - Give the beneficiary follow up **written notice** within **two (2) calendar days.**

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions".**

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.

- **Do not** have access to the state fair hearing process **unless**, the PIHP/CMHSP fails to respond to the grievance **within 60 calendar days.** This constitutes an "action", and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP/CMHSP will:

- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are 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).
- Submit the written grievance to appropriate staff including a PIHP/CMHSP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP/CMHSP received the grievance/complaint. The content of the Notice of disposition must include:

  - The results of the grievance process
  - The date the grievance process was concluded.
  - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
  - How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP/CMHSP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP/CMHSP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP/CMHSP or any of its providers
- The volume of denied claims for services in the most recent year.

XI. RECIPIENT RIGHTS COMPLAINT PROCESS

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 – CMHSP Local Dispute Resolution Process.

REFERENCE
MDCH/PIHP Medicaid Managed Specialty Supports and Services Contract

REVISED:

REVIEWED:

APPROVED: **May 15, 2013**

Signed copy is on file with NMRE
Dave Schneider
Northern Michigan Regional Entity Chief Executive Officer

Date

Signed copy is on file with NMRE
Joe Stone
Northern Michigan Regional Entity Board Chair

Date