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BILL ANALYSIS

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Senate Bill 772 (as introduced 10-14-03)
Sponsor: Senator Tony Stamas
Committee: Health Policy

Date Completed: 10-15-03

CONTENT

The bill would amend the Mental Health Code to do all of the following:

-- Require the Department of Community Health (DCH) to establish a policy directive on local grievance procedures that all community mental health services programs (CMHSPs) would have to follow.
-- Allow a person who was dissatisfied with a CMHSP decision under the local grievance process to request that the DCH Office of Medical Psychiatric Affairs arrange for an external review, under certain circumstances.
-- Require an external reviewer (a psychiatrist or other mental health professional, depending on the case) to make a recommendation to the Office, which would make a binding administrative decision.
-- Establish deadlines, including separate deadlines for emergency situations, within the local grievance and external review processes and for the Office.
-- Require the DCH to give the Legislature an annual report detailing local grievance filings and external review requests.

The bill is discussed below in further detail.

Local Grievance Policy Directive

The bill would require the DCH to establish a policy directive on local grievance procedures that all CMHSPs would have to follow. The policy directive would have to require a CMHSP to reach a decision on a local grievance within 35 calendar days from the date the grievance was filed by an applicant, a recipient, an applicant's or recipient's guardian, or an authorized representative of an applicant, recipient, or guardian. If a mental health professional communicated orally or in writing to a CMHSP that the applicant or recipient was experiencing an emergency situation as defined in Section 100a of the Code, the program would have to reach its decision within 72 hours from the date the grievance was filed.

(Under Section 100a, "emergency situation" means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

-- The individual can reasonably be expected within the near future to injure physically himself, herself, or another person, either intentionally or unintentionally.
-- The individual is unable to provide himself or herself with food, clothing, or shelter or to attend to basic physical activities, such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or another person.
-- The individual's judgment is so impaired that he or she cannot understand the need for treatment and, in the opinion of the mental health professional, his or her continued

behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or another person.)

External Review

The bill would allow a filing applicant, recipient, guardian, or authorized representative who was dissatisfied with a CMHSP's decision under the local grievance process to request within 60 calendar days of the decision, or within 10 calendar days if the grievance represented an emergency situation, that the DCH's Office of Medical Psychiatric Affairs arrange for an external review of the grievance, if both of the following applied:

-- The grievance involved a CMHSP determination that an admission, availability of care, continued stay, or other specialty mental health service or support was denied, reduced, suspended, or terminated due to lack of medical necessity.
-- The applicant or recipient did not have the legal recourse to participate in the Medicaid fair hearing process regarding the CMH services program's determination. (That process is described below in **BACKGROUND**.)

Upon receiving a request for an external review, the Office of Medical Psychiatric Affairs would have to give written notification of receipt to the involved CMHSP. Within five business days of receiving the request, or within 24 hours if the grievance represented an emergency situation, the Office would have to determine whether external review was warranted. The person who filed the grievance and the involved CMHSP would have to receive written notification of the determination according to one of the following:

-- If external review were not warranted, the Office would have to attempt to mediate the disagreement between the person who filed the grievance and the involved CMHSP.
-- If external review were warranted and the service or services in question were solely or primarily of a treatment nature, the Office would have to arrange for the review to be conducted by a psychiatrist who had no employment, contractual, or other relationship with the DCH or any CMHSP.
-- If external review were warranted and the service or services in question were solely or primarily of a support nature, the Office would have to arrange for the review to be conducted by a mental health professional who had no employment, contractual, or other relationship with the DCH or any CMHSP.

In arranging for an external review, the Office immediately would have to forward to the external reviewer written material submitted to the Office by the person who filed the grievance. The external reviewer could request that person to provide additional information within seven business days, or within one business day if the grievance represented an emergency situation.

Upon receiving notification that an external review was to be conducted, the involved CMHSP would have seven business days to provide the external reviewer with all documents and information used by the program in making its local grievance decision. If the grievance represented an emergency situation, the material would have to be provided within one business day, and the initial notification could be verbal. If the CMHSP failed to provide the required material within the prescribed time frame, the Office would have to order an immediate reversal of the local grievance decision.

An external reviewer would have to make a recommendation to the Office within 10 business days after receiving information from a CMHSP or a person who filed a local grievance, or within 48 hours if the grievance represented an emergency situation. Upon receiving the recommendation, the Office would have to make a binding administrative decision about the

case within seven business days, or 48 hours if the grievance represented an emergency situation. Initial notice of the decision could be provided orally to the person who filed the grievance and the CMHSP. In all cases, both parties would have to be given written notification that minimally included the external reviewer's recommendation and the rationale for that recommendation, and, if applicable, the rationale for why the Office did not follow the external reviewer's recommendation.

At any time before the Office made its binding administrative decision, the external review process would be abrogated if the person who filed the grievance made a written request for withdrawal, or the involved CMHSP provided written notification that it had elected to authorize the action sought by the person.

Annual Report

The DCH would have to provide the Legislature annually with a report detailing for each CMHSP and the State in aggregate all of the following, categorized according to emergent or nonemergent status and whether or not the person filing the grievance had legal recourse to participate in the Medicaid fair hearing process:

-- The number of local grievances filed.
-- The number of filed local grievances in which agreement between the parties negated a need for a local grievance decision by the CMHSP.
-- The number of local grievance decisions upholding the initial determination of the CMHSP.

The report also would have to detail for each CMHSP and the State in aggregate all of the following, categorized by emergent and nonemergent status:

-- The number of local grievance decisions resulting in requests for external review.
-- The number of requests for external review that were not honored by the Office, and the outcomes of the Office's mediation efforts for those cases.
-- The number of requests for external review honored by the Office.
-- The number of external review cases in which CMHSPs' failure to provide required material within prescribed time frames resulted in default judgment for the person who filed the grievance.
-- The number of external review cases withdrawn prior to final administrative decision at the request of CMHSPs.
-- The number of external review cases in which the external review recommendation respectively favored CMHSPs and parties filing grievances.
-- The number of external review cases in which the Office overturned the external reviewer recommendation, and the number of those overturned recommendations that respectively favored the CMHSPs and parties filing grievances.

("Emergent status" refers to an emergency situation.)

Proposed MCL 330.1709

BACKGROUND

The Medicaid fair hearing process is mandated under Section 1902(a)(3) of the Federal Social Security Act, which requires that states "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness". According to the Center for Medicare and Medicaid Services, a request for a hearing must be in writing and signed by the applicant or recipient, or an authorized representative. The State agency must attempt to enable a claimant to attend the hearing in person and to be represented by a person of his or

her own choosing. The convenience of the hearing for the claimant must be considered in setting the date, place, and time. If a claimant is house-bound, hospitalized, or in a nursing home, a hearing may be conducted at the claimant's residence or over the telephone.

The hearing officer's recommendation or decision must be based only on the evidence and testimony introduced at the hearing. A conclusive decision in the name of the State agency must be made by the hearing authority, who may be the highest executive officer of the State agency, a panel of agency officials, or an official appointed specifically for that purpose. The hearing authority may either adopt or reject the recommendations of the hearing officer, or refer the matter back to the hearing officer if the materials submitted are insufficient to serve as a basis for a decision. Once the decision has been mailed, the claimant has 15 days to appeal it to the State agency. The hearing authority's decision is binding upon state and local agencies, and must be carried out promptly.

Legislative Analyst: Julie Koval

FISCAL IMPACT

Establishment of the proposed local grievance procedure and the external review clearly would result in costs both for the local CMHSPs and for the State. It is difficult, however, to estimate the cost due to lack of experience with such procedures. Staff would have to be available at the CMHSPs to handle the grievance procedure. Furthermore, if there were more than a minimal number of external reviews, staff would be needed within DCH. The cost is uncertain.

For instance, if there were 100 external reviews requiring an average of 20 hours of staff time apiece, that would equate to one full-time equated employee. Even if various costs such as support work, paperwork, and administrative actions were included, the costs of 100 external reviews averaging 20 hours of staff time would be under $100,000 Gross.

Fiscal Analyst: Steve Angelotti

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