| POLICY TITLE: | MEDICAID GRIEVANCE AND APPEALS – DUE PROCESS | POLICY #6.1 | REVIEW DATES | |
|---|---|---|---|---|
| **Topic Area:** | **CUSTOMER SERVICE** | **ISSUED BY:** LRE Customer Services | 11/21/13 | 1/1/2015 |
| | | | 6/21/2018 | 5/19/22 |
| **Applies to:** | LRE, All Member CMHSPs | | 12/20/22 | 4/10/24 |
| | | **APPROVED BY:** **Chief Executive Officer** | 2/14/25 | |
| **Developed and Maintained by:** | LRE CEO and Designee | | | |
| | | | | |
| **Supersedes:** | N/A | **Effective Date:** January 1, 2014 | **Revised Date:** 2/14/25 | |

## I. PURPOSE

To have appeals, grievances, and hearings processes in place to ensure recipients' due process rights under the federal regulations and contract requirements.

## II. POLICY

The Lakeshore Regional Entity (LRE) delegates the grievance process, consistent with federal and state guidelines to the Community Mental Health Services Programs (CMHSP) with oversight and monitoring by LRE, including:

A. A local grievance process for any recipient of the PIHP to express dissatisfaction about any matter other than those that meet the definition of an "Adverse Benefit Determination" or those that meet the definition of a Recipient Rights issue. The Member's grievance complaint resolution process may occur simultaneously with MDHHS's Administrative Hearing process, as well as the Recipient Rights Investigative process.

B. Complaints should be resolved at the level closest to service delivery when possible but information regarding access to all complaint resolution processes will be provided to the Medicaid Enrollee. The Member may attempt to resolve a dispute through their local processes insofar as the local process shall not supplant or replace the Beneficiary's right to file a grievance or appeal request with LRE or right to request a hearing with MDHHS.

C. Access to the State Fair Hearing process if the CMHSP fails to resolve a grievance within 90 days.

D. All processes will promote the resolution of concerns and improvement of the quality of care.

E. Each CMHSP member shall have a local procedure in place that is in compliance with the Michigan Department of Health and Human Services (MDHHS), Grievance and Appeal Technical Requirement and 42 CFR 438 Subpart F – Grievance System.

F. Lakeshore Regional Entity is responsible for the appeals and state fair hearing processes, consistent with federal and state guidelines.

G. In cooperation with the Michigan Department of Insurance and Financial Services (DFIS) in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act," the PIHP will ensure that consumers have the right to request an external review process for adverse determinations if the consumer has exhausted the PIHP/CMHSP's internal grievance process provided for by law.

## III. APPLICABILITY AND RESPONSIBILITY

This policy applies to LRE and member CMHSPs.

## IV. MONITORING AND REVIEW

LRE CEO and/or designee(s) will review this policy on an annual basis.

## V. DEFINITIONS

**Adverse Benefit Determination:** A decision that adversely impacts the Medicaid Enrollee's claim for services due to: (42 CFR 438.400)

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR 438.400 (b)(1).
- Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).
- Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3).
- Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).
- Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receiving a request for expedited Service Authorization. 42 CFR 438.210(d)(2).
- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. 42 CFR 438.400(b)(4).
- Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).
- Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).
- Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).
- For a resident of a rural area with only one Managed Care Organization (MCO), the denial of the Enrollee's request to exercise his/her right, under § 438.52(b)(2)(ii), and to obtain services outside the network. 42 CFR 438.400(b)(6).
- Denial of the Enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400(b)(7).

**Adequate Notice of Adverse Benefit Determination**: Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. 42 CFR 438.404(c)(2).

**Advance Notice of Adverse Benefit Determination:** Written statement advising the Enrollee

of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided to the Medicaid Enrollee at least 10 calendar days prior to the proposed date the Adverse Benefit Determination takes effect. 42 CFR 438.404(c)(1); 42 CFR 431.211.

**Appeal**: A review at the local level by the PIHP of an Adverse Benefit Determination, as defined above. 42 CFR 438.400.

**Authorization of Services**: The processing of requests for initial and continuing services delivery. 42 CFR 438.210(b).

**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 the PIHP and/or the CMHSP services.

**Due Process:** The process the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them.

**Enrollee:** A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Manager (PCCM), or Primary Care Case Management (PCCM) Entity in a managed care program. 42 CFR 438.2.

**Expedited Appeal:** The expeditious review of an Adverse Benefit Determination, requested by the Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical, or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. 42 CFR 438.410(a).

**Grievance:** The enrollee's expression of dissatisfaction with the PIHP and/or the CMHSP about any matter other than an adverse benefit determination grievances may include, but are not limited to, any aspect of the operations, activities, or behavior of PIHP or its Provider Network, regardless of whether remedial action is requested. Specific examples include the quality of care or services provided, problems getting an appointment or having to wait a long time for an appointment, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right to dispute an extension of time proposed by the PIHP to make a service authorization decision. (*42 CFR 438.400(b))***Grievance Process:** Impartial local level review of the Enrollee's Grievance.

**Grievance and Appeal System:** The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. 42 CFR 438.400.

**Hearing Officer:** Staff person assigned to coordinate the State Fair Hearing process, representing the PIHP/CMHSP/Provider Network

**Medicaid Services:** Services provided to the Enrollee under the authority of the Medicaid State

Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act (SSA).

**Notice of Resolution:** Written statement of the PIHP of the resolution of an Appeal or Grievance, which must be provided to the Enrollee as described in 42 CFR 438.408.

**PIHP:** Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic area under contract with the State. There are 10 PIHPs in Michigan and each one is organized as a Regional Entity or a Community Mental Health Services Program according to the Mental Health Code.

**Service Authorization:** The PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

**State Fair Hearing**: Impartial state-level review of the Medicaid Enrollee's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. Also referred to as an "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

**Substantiated:** The decision that there is sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

**Unsubstantiated:** The decision that there is not sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

## VI. RELATED POLICIES AND PROCEDURES

A. LRE Customer Service Policies and Procedures
B. LRE Quality Policies and Procedures
C. LRE Corporate Compliance Plan
D. LRE QAPIP

## VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Specialty Supports and Services Contract
B. MDHHS Appeal and Grievance Resolution Processes Technical Requirement
C. 42 CFR 438.10
D. 42 CFR 431.200
E. 42 CFR 438.400
F. 42 CFR 438.404(c)(1)
G. 42 CFR 431.211
H. 42 CFR 431
I. MI Mental Health Code
J. LRE Provider Service Contract

## VIII. CHANGE LOG

| Date of Change | Description of Change | Responsible Party |
|---|---|---|
| 8/2021 | | CEO |
| 11/17/22 | | CEO |
| 2/8/2023 | Added MDHHS Requirement of Right to Independent Review | LRE Customer Services |
| 4/10/24 | Language added to II.A, II.B | LRE Customer Services |
| 2/14/25 | Review and language updated | LRE Customer Services |