PROCEDURE TITLE: 6.1a DUE PROCESS – GRIEVANCE AND APPEALS	EFFECTIVE DATE	REVISED DATE
TOPIC AREA: CUSTOMER SERVICES	6/21/2018	11/17/2022
ATTACHMENT TO	REVIEW DATES	
POLICY #: 6.1	5/22/2023	
POLICY TITLE: GRIEVANCE, APPEALS & DUE PROCESS		
CHAPTER: NA		

I. PURPOSE

To ensure Lakeshore Regional Entity (LRE) Prepaid Inpatient Health Plan (PIHP), Member Community Mental Health Programs (CMHSPs) and the Provider Network have a due process systems in place that meets Michigan Department of Health and Human Services (MDHHS) requirements.

II. PROCEDURES

The following standards and procedures shall be applied.

A. General Standards

1. Consumers of publicly funded services may access several options to pursue the resolution of complaints. These options include the right to file a local (internal) appeal, the rights to a State Fair Hearing, the right to file a grievance, the right to file a Recipient Rights Violation complaint, and the right to a second opinion.
2. During the initial contact with "Access", the applicant shall be provided information on the due process system.
3. Individuals who wish to file a complaint may do so independently or with the assistance of Customer Services, other available staff, or a person of their choosing. A provider may not refuse to assist the individual who needs help in filing a complaint and submitting that complaint for resolution.
4. PIHP/CMHSP/organizational providers will provide reasonable assistance to complete forms and take procedural steps. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
5. The PIHP/CMHSP must provide information about the due process/grievance and appeals system to all providers and subcontractors at the time they enter a contract.
6. Record of all grievance and appeals will be maintained for a period of 10 years. Documentation shall include:
    a. General description of the reason for the grievance or appeal.
    b. The date received.

c. The date of each review, or if applicable, the review meeting.
d. The resolution at each level of the appeal or grievance, if applicable.
e. Name of the covered individual for whom the appeal or grievance was filed.

7. The PIHP will monitor as outlined in the contract.
8. PIHP/CMHSP communication will meet all MDHHS content requirements. When applicable, MDHHS standardized notification templates will be used including adverse benefit determination letters, acknowledgement receipts, extension communication, resolution determinations.
9. PIHP/CMHSP ensures the individual(s) who make decisions for grievances are individuals:
    a. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
    b. When the grievance/appeal involves (i.) clinical issues, or (ii.) denial of expedited resolution of Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the individual's conditions or disease.
    c. Consider all comments, documents, records, and other information submitted by the individual or their representative without regard to whether such information was considered in the initial Adverse Benefit Determination.

B. Grievances

Grievances are expressions of dissatisfaction about services other than Adverse Benefit Determinations.

1. A grievance may be filed at any time by the Beneficiary, guardian, parent of minor child, or legal representative.
2. A grievance may be filed orally or in writing.
3. A grievance must be resolved within 90 calendar days from the date of receipt.
4. A state fair hearing is only allowed if the grievance is resolved past the 90-calendar-day timeframe requirement.
5. The timeframe for grievance resolution and notice may be extended for up to 14 calendar days if the individual requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information on how the delay is in the individual's best interest.
6. If the grievance resolution timeframe is extended, the PIHP must complete all of the following:
    a. Make reasonable efforts to give the individual prompt oral notice of the delay.
    b. Within 2 calendar days, give the individual written notice of the reason for the decision to extend the timeframe and inform the individual of the right to file a grievance if they disagree with the decision.
    c. Resolve the grievance as expeditiously as the individual's health condition requires and not later than the date the extension expires.
7. Resolution of Notice shall contain:
    a. The results of the Grievance process.

b. The date of the Grievance process was concluded.
c. Notice of the Beneficiary's right to request a State Fair Hearing if the notice of resolution is more than 90 calendar days from the date of the grievances, and
d. Instructions on how to access the State Fair Hearing process, if applicable.

C. Notice of Adverse Benefit Determination

The PIHP, Member CMHSPs, and organizational providers will utilize the Notice of Adverse Benefit Determination as identified by MDHHS, for any decisions that adversely impacts Beneficiary's services or supports.

1. Content of the notice must include:
   a. A description of the determination, i.e., termination, denial, suspension, etc.
   b. The reason for the determination.
   c. The policy/authority relied upon making the decision.
   d. The effective date of the determination.
   e. The right to file an Appeal and instructions on how to do so.
   f. The right to a State Fair Hearing should the PIHP fail to provide timely notice, or failure to provide Notice of Resolution within the required timeframes.
   g. The circumstances under which an expedited appeal can be requested and instructions for doing so.
   h. The explanation the individual may represent themselves or use legal counsel, a relative, a friend, or other spokesperson, or the legal representative of a deceased member's estate.
   i. The right for the Beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Beneficiary's Adverse Benefit Determination (including medical necessity criteria, processes, strategies, or evidentiary standards used in setting coverage limits).
   j. The Beneficiary's right to have benefits continue pending resolution of the Appeal; instructions on how to request benefit continuation. (Advance Notice only).
   k. That 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
2. Timing of Notices
   a. Adequate notice is given/mailed to the Individual/Guardian on the effective date. Adequate notice is used in the following determinations:
      i. Denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the action affecting the claim.
      ii. For a Service Authorization decision that denies or limits services, notice must be provided to the individual within 14 calendar days following receipt of the request for service for standard authorization decisions, or within 72 hours after the receipt of a request for an expedited authorization decision.

b. Service authorization decisions not reached within 14 calendar days for a standard request, or 72 hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination) on the date that the timeframes expire.
c. Extensions on Timeframes: The PIHP may be able to extend the standard (14 calendar day) or expedited (72 hour) Service Authorization timeframes for up to an additional 14 calendars days if the individual requests the extension, or if the PIHP can show that there is a need for additional information and the extension is in the individual's best interest. If the PIHP extends the timeframe NOT at the request of the individual, the PIHP must:
    i. make reasonable efforts to give the individual oral notice of the delay.
    ii. within 2 calendar days, provide the individual written notice of the right to file a Grievance if they disagree with that decision.
    iii. Issue and carry out its determination as expeditiously as the individual's health condition requests and no later than the date the extension expires.
d. Advance Notice of Adverse Benefit Determination is given/mailed to Beneficiary/Guardian a minimum of 10 calendar days prior to the proposed effective date of the determination for reductions, suspensions, or termination of previously authorized/currently provided Medicaid Services.
e. Limited Exceptions: The PIHP may mail and adequate notice of action not later than the date of the action to terminate, suspend, or reduce previously authorized services IF:
    i. There is factual information confirming the death of the individual.
    ii. The PIHP receives a clear written statement signed by the individual that they no longer wish services, or that gives information that requires the termination or reduction of services and indicates that the individual understands that this must be the result of supplying that information.
    iii. The individual has been admitted to an institution where they are ineligible under Medicaid for further services.
    iv. The individuals' whereabouts are unknown, and the post office returns agency mail directed to them indicating no forwarding address.
    v. The PIHP establishes that the individual has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
    vi. A change in the level of medical care is prescribed by the individual's physician.
    vii. Then notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the SSA.
    viii. The date of the action will occur in less than 10 calendar days.
    ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the individual (in this case, the PIHP may shorten the period of the advance notice to 5 calendar days before the date of action).

D. Appeals

Beneficiary(ies) may pursue the option to dispute/appeal any Adverse Benefit Determination. The Appeal with the PIHP is the first step in the appeal process and must be completed prior to the State Fair Hearing.

1. Individuals are given 60 calendar days from the date of the Notice of Adverse Benefit Determination to request the Appeal.
2. The individual may request an Appeal either orally or in writing. Unless the individual requests an expedited resolution, oral inquiries seeking appeal of an Adverse Benefit Determination are treated as requests for filing to establish the earliest possible filing date for the appeal. A provider or other authorized representative may file an appeal on an individual's behalf with written permission from the individual.
3. Upon request, the individual will be given assistance from staff in the filing process, including explanation of the process and/or completing forms. This also includes, but is not limited to: providing interpretive services, auxiliary aids and services upon request, and toll-free number with interpreter capabilities.
4. Expedited Appeals: Expedited appeals are available where the PIHP determines (at the request from the individual or the provider making a request on the Individual's behalf or supporting the individual's request) that the timeframe for the standard resolution could seriously jeopardize the Individual's life, physical or mental health or ability to attain, maintain, or regain maximum function. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an individual's appeal.
    a. If a request for expedited appeal is denied, the PIHP must:
        i. Transfer the appeal to the timeframe for standard resolution.
        ii. Make reasonable efforts to give the individual prompt oral notice or the denial.
        iii. Within two (2) calendar days with a written notice of the reason for the decision to extend the timeframe and inform the individual of the right to file a grievance if they disagree with the decision.
        iv. Resolve the appeal as expeditiously as the individual's health condition requires, but not to exceed 30 calendar days.
    b. If the request is granted PIHP must resolve the Appeal and provide notice of resolution with 72 hours after the PIHP receives the request for expedited resolution of the appeal.
    c. If members request a copy of their case file in advance of an expedited appeal resolution, the PIHP would take actions to ensure that members would receive the file in a timely manner (e.g., overnight mail, in-person drop-off, secure email with member permission).
5. The PIHP may extend the resolution and notice timeframe by up to 14 calendar days if the individual requests an extension, or if the PIHP shows the satisfaction of the State that there is a need for additional information, and how the delay is in the individual's best interest. If the PIHP extends the resolution/notice timeframes, it must complete **all** of the following:

a. Make reasonable efforts to give the individual prompt oral notice of the delay.
b. Within 2 calendar days, give the individual written notice of the reason for the decision to extend the timeframe and inform the Beneficiary of the right to file a grievance if they disagree with the decision.
c. Resolve the appeal as expeditiously as the individual's health condition requires and not later than the date the extension expires.

6. Notice of Resolution shall contain:
   a. A general description of the reason for appeal.
   b. The date received.
   c. The date the review process.
   d. The results of the appeal process.
   e. The date of resolution.
   f. If the resolution is not resolved wholly in favor of the individual, the notice must also include:
      i. The right to a State Fair Hearing, instructions on how to file
      ii. Timeframe of 120 calendar days to request a State Fair Hearing.
      iii. The right to have services continue, if all conditions are met in section "F" of this policy, and instructions on how to request continuation of service.
      iv. Potential liability for the cost of those benefits if the hearing decision uphold the PIHP's Adverse Benefit Determination.

E. State Fair Hearing
   1. Individuals have the right to an impartial review by a state level administrative law judge (State Fair Hearing), after notice of resolution of the Appeal upholding an Adverse Benefit Determination.
   2. A State Fair Hearing is allowed if the PIHP fails to adhere to the notice and timing requirements for the resolution of grievances and appeals.
   3. The PIHP may not limit or interfere with an individual's freedom to make a request for a State Fair Hearing.
   4. Individuals are given 120 calendar days from the date of the Notice of Resolution from the PIHP Appeal process to file a State Fair Hearing.
   5. The PIHP must include as parties to the State Fair Hearing:
      a. The member and his or her representative.
      b. The legal representative of a deceased member's estate.
      c. The PIHP.

F. Continuation of Benefits Pending Appeal
   1. Beneficiary may request services to continue while waiting for appeal if all the following are true:
      a. The Beneficiary files the appeal in a timely manner, within 10 calendar days of the date of the notice, before or on the effective date indicated on the notice.
      b. The appeal involves an Adverse Benefit Determination of termination,

reduction, or suspension of a previously authorized service.

c. The services were ordered by an authorized provider.
d. The Beneficiary must ask for services to continue.
e. The original authorization for the service has not expired.

2. Benefits must continue (if all conditions above are met) until one of the following occurs:
   a. The Beneficiary withdraws the appeal.
   b. The Beneficiary fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP sends the Beneficiary the Notice of Resolution, upon completion of the appeal.
   c. The State Fair Hearing office issues a hearing decision adverse to the individual.
   d. The duration of the previously authorized service has ended.
3. If the individual's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the action.
4. If the PIHP or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PIHP must pay for those services.

III. APPLICABILITY AND RESPONSIBILITY

This procedure applies to LRE CEO and designee, Member CMHSPs, and Network Providers.

IV. MONITORING AND REVIEW

The LRE Chief Executive Officer will review this procedure on an annual basis.

V. DEFINITIONS

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an "access center," where Medicaid beneficiaries call or go to request behavioral health services.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary's claim for services.

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

Adequate Notice of Adverse Benefit Determination: Written statement advising the Beneficiary of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Beneficiary on the same date the Adverse Benefit Determination takes effect.

Advance Notice of Adverse Benefit Determination: Written statement advising the Beneficiary of a decision to reduce, suspend or terminate Medicaid services currently provided/mailed to the Medicaid Beneficiary at least 10 calendar days prior to the proposed date the Adverse Benefit Determination is to take effect.

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination. **Applicant:** A

person, or his/her legal representative, who makes a request for mental health or substance use disorder services.

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

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.

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.

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

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Beneficiary, failure to respect the Beneficiary's rights regardless of whether remedial action is requested, or an individual dispute regarding an extension of time proposed by the PIHP to make a service authorized decision.

Grievance Process: Impartial local level review of an individual's grievance.

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

Individual: A person who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. Also referred to interchangeably, for purposes of this procedure, as beneficiary or Enrollee.

Medicaid Services: Services provided to an individual under the authority of the Medicaid State Plan, 1915 (c) Habilitation Supports Waiver, and/or Section 1915 (b)(3) of the Social Security Act.

Mental Health Professional: A person who is trained and experienced in mental illness or intellectual/developmental disabilities, as identified per MDHHS staff qualification criteria.
Notice of Resolution: Written statement from the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Beneficiary, as described in 42 CFR 438.408.

Organizational Provider: Entities under contract with the PIHP that directly employ and/or contract with individuals to provide specialty services and supports. Examples of organizational providers include, but are not limited to CMHSPs, hospitals, psychiatric hospitals, partial hospitalization programs, substance use disorder providers, case management programs, assertive community treatment programs, and skill building programs.

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.

Recipient Rights Complaint: Written or verbal statement by an individual, or anyone acting on behalf of the Beneficiary, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved though the processes established in Chapter 7a.

Second Opinion: A request for another assessment by an applicant who has been denied mental health services or a recipient who is seeking and has been denied hospitalization.

Service Authorization: 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 requested under the applicable law, including but not limited to 42 CFR 438.201.

SSA- Social Security Act

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

VI. RELATED POLICIES AND PROCEDURES

A. LRE Customer Service Policies and Procedures
B. LRE Compliance Policies and Procedures
C. LRE Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY

G. MDHHS Medicaid Specialty Supports and Services Contract
H. MDHHS Appeal and Grievance Resolution Processes Technical Requirement
I. 42 CFR 438.10
J. 42 CFR 431.200
K. 42 CFR 438.400
L. 42 CFR 438.404(c)(1)
M. 42 CFR 431.211
N. 42 CFR 431
O. MI Mental Health Code

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
5/19/22	Changed from policy to procedure	CEO
11/17/2022	Updated Language	CEO
5/23/2023	Updated language, error correction	CEO