PROCEDURE # 6.1a		EFFECTIVE DATE	REVISED DATE
TITLE:	GRIEVANCE, APPEALS & DUE PROCESS PROCEDURE	6/21/2018	2/2/2026
ATTACHMENT TO		REVIEW DATES	
POLICY #:	6.1	5/22/23, 5/8/24, 12/11/24, 2/2/26	
POLICY TITLE:	GRIEVANCE, APPEALS & DUE PROCESS		
CHAPTER:	CUSTOMER SERVICES		

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 system 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 right 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, notice must be provided to the Enrollee at the time of the action affecting the claim. Oral or written notice must be given to the provider.
        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.
    a. 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.
    b. A provider or other authorized representative may file an appeal on an individual's behalf with written permission from the individual.
    c. If an appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the member, the 30-day time frame begins on the date an authorized representative document is received by the PIHP. The PIHP must notify the member that an authorized representative form or document is required. For purposes of section Schedule A—1(M)(1)(e)(vii), "third party" includes, but is not limited to, health care providers.
2. The PIHP must acknowledge receipt of each standard Appeal within five (5) business days (42 CFR 438.406(b)(1); 42 CFR 438.408(b)(3)).
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. The PIHP must provide the enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. The PIHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals (42 CFR 438.406(b)(4))
5. Expedited Appeals: Expedited appeals are available where the PIHP determines (at the request of 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. The PIHP must acknowledge receipt of an expedited Appeal within 72 hours of receipt.
    b. 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 of 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.
    c. If the request is granted PIHP must resolve the Appeal and provide notice of

resolution within 72 hours after the PIHP receives the request for expedited resolution of the appeal.

d. 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).

6. 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.
7. 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 upholds 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.
5. In accordance with 42 CFR 438.420(d), if the final resolution of the appeal or State Fair Hearing is adverse to the beneficiary, that is, upholds the adverse benefit determination, LRE or Member CMHSP may, consistent with the State's usual policy on recoveries under 42 CFR 431.230(b) recover the cost of services furnished to the beneficiary while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the MDHHS Grievance and Appeals requirements.

III. SUPPORTING DOCUMENTS

A. Policy 7.1 – Quality Management
B. Policy 9.1 – Corporate Compliance Plan
C. LRE Corporate Compliance Plan

IV. CHANGE LOG

Date of Change	Description of Change	Responsible Party
5/19/22	NEW procedure (removed from policy)	CEO

11/17/2022	Updated Language	CEO
5/23/2023	Updated language, error correction	CEO
4/10/24	Added Section D.5, Removed definitions	CEO
12/11/2024	Minor edits	CEO
2/2/2026	Added language to section D.1	LRE Customer Services