PROCEDURE TITLE: MEDICAID GRIEVANCE AND APPEALS REPORTING	PROCEDURE#	
Topic Area: CUSTOMER SERVICE Related Policy: 6.1 Grievance and Appeals		REVIEW DATES
Applies to: LRE, All Member CMHSPs **Review Cycle:** Annual	**ISSUED BY:** Chief Executive Officer	11/21/13 / 1/1/2015 6/21/2018
Developed and Maintained by: CEO and Designee	**APPROVED BY:** Board of Directors	
Supersedes: N/A	**Effective Date:** January 1, 2014	**Revised Date:** 5/19/22

I. PURPOSE

To establish a process for Community Mental Health Service Program (CMSHP) Participants to report the status of State Fair Hearings and Recipient Rights to Lakeshore Regional Entity (LRE). Also, to establish a process for CMHSP members to report local complaints, appeals, and grievances related to dissatisfaction with services authorized and/or delivered by LRE's Provider Network. This is inclusive of services for people with a Mental Illness (MI), Intellectual Developmental Disability (IDD) and Substance Use Disorders (SUD). The data collected will be used by the LRE Customer Service to review and monitor any trends or outliers and ensure all applicable guidelines are being followed.

II. PROCEDURES

A. Medicaid Denial, Grievance, Appeals, and Second Opinion Report

1. Each report shall be submitted per the Appeals and Grievance Project Description Study (Exhibit 1)
2. Required reporting includes the following Indicators:
   a. Indicator #1 Timeliness of Denials
   b. Indicator # 2 Timeliness of Appeals
   c. Indicator #3 Timeliness of Second Opinion (Applicable only to CMHSP Participant Services; not SUD Services)
   d. Indicator #4 Timeliness of Response to Grievances
3. The reporting template shall be completed in its entirety prior to submission of the report data and must include any Grievance and Appeals detail information which closed during the reporting timeframe.
4. The data submission is based upon quarterly data within the fiscal year (FY) and is due on the following dates:
   a. March 31: FY Quarter 1 (September – December)
   b. June 30: FY Quarter 2 (January – March)
   c. September 30: FY Quarter 3 (April – June)
   d. December 31: FY Quarter 4 (July – September)
5. Reporting shall be submitted to the LRE via SharePoint Reporting.

B. Recipient Rights Report for Indicator #11
   1. The Recipient Rights Report (Exhibit 3) is due to LRE and required to be submitted on the following dates:
      a) June 15: October – March (semi-annual report)
      b) December 15: October – September (annual report)
   2. Reporting shall be submitted to the LRE via SharePoint Reporting.

C. Medicaid Fair Hearings Report
   1. Each report shall be documented on the Medicaid Fair Hearings Report (Exhibit 2). The required reporting includes:
      a) Semi-annual
      b) PIHP or CMHSP Participant Name;
      c) County;
      d) Provider Name;
      e) Number of Requests for Hearing During the Reporting Period;
      f) Number of Hearings Held During the Reporting Period;
      g) Number of Hearings Held During the Reporting Period that Resulted in Favor of Consumer;
      h) Number of Hearings Held During the Reporting Period that Resulted in Favor of CMHSP Participant or PIHP;
      i) Number of Orders of Dismissal Received from MAHS During the Reporting Period;
      j) Number of Hearings Held During the Reporting Period Due to Suspension of Services;
      k) Number of Hearings Held During the Reporting Period Due to Reduction of Services;
      l) Number of Hearings Held During the Reporting Period Due to Termination of Services;
      m) Number of Hearings Held During the Reporting Period Due to Denial of Services;
      n) Number of Hearings Held During the Reporting Period Due to Administrative Discharge (Relevant to SUD); and
      o) Total.
   3. The documentation shall be complete in its entirety prior to submission of report
   4. The Medicaid Fair Hearings Report to LRE is due and required to be submitted on the following dates:
      a) January 31: April 1 – September 30 data
      b) July 31: October 1 – March 31 data
   5. Reporting shall be submitted to the LRE via SharePoint Reporting.

III. APPLICABILITY AND RESPONSIBILITY

This procedure applies to LRE staff, CMHSP members, and the LRE Provider Network.

IV. MONITORING AND REVIEW

This procedure will be reviewed by the Chief Executive Officer 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 receipt of 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.

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 about the PIHP and/or the CMHSP services 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 Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or the Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. 42 CFR 438.400.

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.

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.

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

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.

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 438.408
G. MI Mental Health Code
H. LRE Provider Service Contract

VIII. ATTACHMENTS

A. Exhibit 1- Appeals and Grievance Project Description Study
B. Exhibit 2- Medicaid Fair Hearings Report

IX. CHANGE LOG

Date of Change	Description of Change	Responsible Party
5/19/22		CEO