MSHN
Mid-State Health Network

# POLICIES AND PROCEDURE MANUAL

| Chapter: | Customer Service | | |
|---|---|---|---|
| Title: | Medicaid Enrollee Appeals/Grievances Procedure | | |
| Policy: ☐<br>Procedure:☒<br>Page: 1 of 8 | Review Cycle: Biennial<br>Author: Chief Compliance and Quality Officer; Customer Service Committee | Adopted Date: 07.02.2024<br>Review Date: 07.07.2026 | Related Policies:<br>Consumer Service Policy |

## Purpose

The Medicaid Enrollee Appeals/Grievances Procedure defines the process for the resolution of appeals and grievances in accordance with federal and state standards.

## Procedure

The following will be followed in accordance with the MSHN Medicaid Enrollee Appeals/Grievances Policy.

1) Timely notice of any Adverse Benefit Determination (ABD) decisions is required, and Notices must utilize the state-developed template. The Notice must:
   a) Be in writing and must meet the requirements of 42 Code of Federal Regulations (CFR) 438.10;
   b) Include notification 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;
   c) The ABD must include:
      - A description of the ABD,
      - The reason for the ABD,
      - The policy/authority relied upon in making the determination,
      - Notification of the enrollee's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the ABD;
   d) Include notification of the individual's right to request an Appeal, including information on exhausting the local Appeal process, and the right to request a State Fair Hearing thereafter;
   e) A description of the circumstances under which an Appeal can be expedited and how to request an expedited Appeal;
   f) The notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services;
   g) A description of the procedures that the Enrollee is required to follow to exercise any of these rights;
   h) An explanation that the Enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman as a designated representative.
2) An adequate ABD Notice must be provided at the time of decision for a denial of payment for a requested service, a denied or limited service authorization decision, and/or a service authorization

decision not reached within 14 calendar days for a standard request or 72 hours for an expedited request.

3) An advanced ABD Notice must be provided to an Enrollee at least ten (10) calendar days prior to the proposed effective date for reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services. Limited exceptions are present (see 42 CFR 431.213; 42 CFR 431.214) that state an adequate notice of action not later than the date of action to terminate, suspend, or reduce previously authorized services, may be sent in place of an advanced ABD Notice if an exception reason occurs.

4) If the Enrollee's services were reduced, terminated, or suspended without advance notice, the Pre-paid Inpatient Health Plan (PIHP) must reinstate services to the level before the Adverse Benefit Determination.

5) The timeframe for standard (14 calendar days) or expedited (72 hours) Service Authorization requests, Appeals (30 days), and/or Grievances (90 days) may be extended for up to an additional 14 calendar days if either the Enrollee requests the extension, or if the provider can show that there is a need for additional information and the extension is in the Enrollee's best interest (42 CFR 438.210(d)(1)(ii)). If the provider extends the time NOT at the request of the Enrollee, the provider must:
   a) Extend the timeframe before the initial timeframe has expired;
   b) Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
   c) Within two (2) calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he/she disagrees with that decision;
   d) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

6) After receipt of an Adverse Benefit Determination Notice, the Enrollee has the right to appeal the determination through a one-level internal review by the provider.
   a) The Enrollee may request an Appeal under the following conditions:
      - The Enrollee has 60 calendar days from the date of the notice of Adverse Benefit Determination to request an Appeal;
      - The Enrollee may request an Appeal either orally or in writing. Oral requests begin the appeal process to establish the initial request date for the Appeal;
      - Benefits may be continued/reinstated for Medicaid services if the conditions with the "Continuation of Benefits" (Section E) are met
   b) When the Enrollee Requests an Appeal, the provider must:
      - Provide reasonable assistance to complete forms and take other procedural steps. Including, but not limited to: auxiliary aids and services, upon request, such as providing interpreter services;
      - Resolve each appeal, and provide notice, as quickly as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in 42 CFR 438.408.
      - Acknowledge receipt of an expedited Appeal within 72 hours of receipt and a standard Appeal within five (5) business days;
      - Maintain a record of Appeals for review;
      - Ensure that the individual(s) who make the decisions on Appeals:
        - Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;
        - When deciding an Appeal that involves either (i.) clinical issues, or (ii.) a denial based on

lack of medical necessity, are individual(s) who have the appropriate clinical expertise in treating the Enrollee's condition or disease;
    - Consider all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- Provide the Enrollee with a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing, and inform the Enrollee of the limited time available for this in advance of the resolution timeframe for Appeals;
- Provide the Enrollee and his/her representative with the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated in connection with the Appeal. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals;
- Provide an opportunity to include as parties to the Appeal the Enrollee and his/her representative or the legal representative of a deceased Enrollee's estate;
- Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.
- Provide an opportunity to include as parties to the Appeal the Enrollee and his/her representative or the legal representative of a deceased Enrollee's estate;

c) Appeal Resolution Timing:
- Standard Appeal requests must be resolved as expeditiously as the Enrollee's health condition requires, but not to exceed 30 calendar days from the day of request.
- Expedited Appeal requests must be resolved within 72 hours from the time of the Enrollee's request. Note: The appeal timeframe may be extended up to 14 calendar days. See Section 5.
    - If an Enrollee's Expedited Appeal request is denied, the provider must:
        (a) Transfer the Appeal to the standard resolution timeframe,
        (b) Make reasonable efforts to give the Enrollee prompt oral notice of the denial,
        (c) Give the Enrollee written notice of the reason for the decision to deny within two (2) calendar days,
        (d) Inform the Enrollee of their right to file a Grievance if they disagree with the decision to deny,
        (e) Resolve the Appeal as expeditiously as the Enrollee's health condition requires, but not to exceed the standard Appeal resolution timeframe.

d) Appeal Resolution Notice
- Written notice of the Appeal resolution utilizing the state developed template must be provided.
- The notice must meet the requirements of 42 CFR 438.10
- The Appeal resolution notice must include the results of the resolution and the date it was completed.
- When the Appeal is not resolved wholly in favor of the Enrollee, the notice must also include:
    - The Enrollee's right to request a State Fair Hearing and how to do so;
    - The right to request to receive benefits while the State Fair Hearing is pending, and how to make the request; and
    - The potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination.

e) Continuation of Benefits
- If an Appeal involves the termination, suspension, or reduction of previously authorized services, the provider MUST continue the Enrollee's benefits if all the following occur:
    - The Enrollee files the Appeal request within 60 calendar days from the date on the Adverse Benefit Determination Notice;

- The Enrollee requests for a continuation of benefits on or before the latter of 10 calendar days from the date of the notice of Adverse Benefit Determination or the intended effective date of the proposed Adverse Benefit Determination and
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired.

- The Enrollee's benefits will continue while the Appeal or State Fair Hearing is pending until one of the following occurs:
  - The Enrollee withdraws the Appeal or request for a State Fair Hearing,
  - The Enrollee fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;
  - A State Fair Hearing office issues a decision adverse to the Enrollee.

7) Enrollees have the right to a Grievance process to seek resolution to issues that are not Adverse Benefit Determinations.

   a) The Enrollee must file a Grievance with the local provider approved and administratively responsible for facilitating the resolution of the Grievance.

   b) A Grievance may be filed at any time by the Enrollee, guardian, or parent of a minor child, or his/her legal representative.

   c) Resolve each grievance, and provide notice, as quickly as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in 42 CFR 438.408.

   d) The Provider must:
      - Provide the Enrollee with reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services;
      - Acknowledge receipt of the Grievance within five (5) days;
      - Maintain a record of Grievances for review.

   e) Ensure that the individual(s) who make the decisions on the Grievance:
      - Were not involved in any previous level review or decision-making, nor a subordinate of any such individual;
      - When the Grievance involves either clinical issues or a denial of expedited resolution of an Appeal, staff must have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease;
      - Consider all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination;
      - Submit the written Grievance to the individual or entity with the authority to require corrective action.

8) Grievance Resolution

   a) A written notice of resolution not to exceed 90 calendar days from the day the Grievance is received must be provided to the Enrollee.
      - Note: The grievance timeframe may be extended up to 14 calendar days. See section 5.

   b) The Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10.

c) The notice of Grievance resolution must include:
   - The results of the Grievance process;
   - The date the Grievance process was concluded;
   - The resolution Notice must include instructions on how to access the State Fair Hearing process if the Grievance resolution is more than 90 calendar days from the date of the Grievance receipt.

9) State Fair Hearing Process

a) Enrollees have the right to a State Fair Hearing by a State Level Administrative Law Judge for an adverse action in certain circumstances:
   - After receiving an Appeal resolution notice upholding an Adverse Benefit Determination;
   - When the PIHP fails to adhere to the notice and timing requirements for resolution of Appeals and Grievances.

b) The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met.
   - The review must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing.
   - The review must be independent of both the State and the PIHP.
   - The review must be offered without any cost to the enrollee.
   - The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits.

c) The PIHP may not limit or interfere with the Enrollee's freedom to request a State Fair Hearing.

d) The Enrollee is given 120 calendar days from the date of the applicable Notice of Resolution to submit a request for a State Fair Hearing.

e) If the enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination.

f) The parties to the State Fair Hearing include the Enrollee and his/her representative, or the representative of a deceased Enrollee's estate, and the local agency that made the determination.

   - A Recipient Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

g) Expedited hearings are available.

10) All processes will promote resolving concerns and improving the quality of care in compliance with the Michigan Department of Health and Human Services (MDHHS) Grievance and Appeal Technical Requirement, and 42 CFR 438 Subpart F – Grievance and Appeal System.

**Applies to**:

☒ All Mid-State Health Network Staff Selected
☐ MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: ☐Policy Only ☒Policy and Procedure
☒ Other: Sub-contract Providers

**Definitions:**

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

*a.* 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).*

*b.* Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*

*c.* Denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. *42 CFR 438.400(b)(3).*

d. 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*).

*e.* 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).*

*f.* Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*

*g.* 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).*

*h.* 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).*

*i.* 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).*

*j.* For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*

*k.* Denial of an 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/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

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

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

CFR: Code of Federal Regulations

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.

CMHSP: Community Mental Health Service Program

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM

entity in a given managed care program**.** *42 CFR 438.2*.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an 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 grievance 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*.

Grievance Process: Impartial local level review of an 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 an Enrollee under the authority of the Medicaid State Plan, 1115 Behavioral Health Demonstration Waiver, Healthy Michigan Plan, MIChild, 1915(i) Waiver, 1915(c) Waivers, and/or Section 1915(b)(3) of the Social Security Act (SSA).

MSHN: Mid-State Health Network

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

PIHP: Prepaid Inpatient Health Plan.

Recipient Rights Complaint: Written or verbal statement by an 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: 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 a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

SUD Provider Network: Refers to a SUD Provider that is directly under contract with PIHP MSHN to provide services and/or supports

**Other Related Materials:**

N/A

**References/Legal Authority:**

The following federal and state statutes establish the standards for MSHN's Appeals and Grievance procedures for Medicaid Recipients:

1. 42 CFR 438.10: Information Requirements
2. 42 CFR 431.200: Fair Hearings
3. 42 CFR 438.400: Appeals and Grievances
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements; L. Grievances and Appeals Process for Beneficiaries

5. State of Michigan/PIHP Contract attachment: Appeals and Grievances Technical Requirements (P.6.3.1.1)
6. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)
7. Michigan Mental Health Code (MHC) MCL 330.1705 (Medicaid Second Opinion)

**Change Log**:

| **Date of Change** | **Description of Change** | **Responsible Party** |
|---|---|---|
| 01.22.2024 | New Procedure | Chief Compliance and Quality Officer, Customer Service Committee |
| 01.26.2026 | Language updated based on HSAG Compliance Review feedback and updates from the PIHP Customer Service Standards | Chief Compliance and Quality Officer, Customer Service Committee |