MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Reporting Medicaid Beneficiary Appeals, Grievances, MCPAR, and State Fair Hearings**		
Policy: ☐ **Procedure:** ☑ **Page** 1 of 5	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 05.18.2015 **Review Date: 07.07.2026**	**Related Policies:** Customer Services Policy Medicaid Beneficiary Appeals/Grievances Policy

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 Mid-State Health Network (MSHN). Also, to establish a process for Community Mental Health Services Program (CMHSP) Participants and Substance Use Disorder (SUD) Providers to report local complaints, appeals, and grievances related to dissatisfaction with services authorized and/or delivered by Mid-State Health Network's (MSHN) 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 Customer Service Committee to review and monitor trends or outliers and to ensure all applicable guidelines are being followed.

MSHN delegates the responsibility for reporting the status of State Fair Hearings, including complaints, appeals, and grievances consistent with federal and state guidelines, to the CMHSP Participants/SUD Provider Network. MSHN will provide oversight and monitoring of the process. The Customer Service Committee is responsible for addressing any concerns or trends where policy and/or protocol is not being followed.

Procedure

A. **Michigan Department of Health and Human Services (MDHHS) Medicaid Grievance Reporting**

1. The MDHHS reporting template shall be completed in its entirety prior to submission of the report data and must include any Grievance detail information that closed during the reporting quarter.
2. The data submission is based upon quarterly data within the fiscal year (FY) and is due by the 1st of the second month following the end of each quarter on the following dates:
    a. February 1: FY Quarter 1 (September – December)
    b. May 1: FY Quarter 2 (January – March)
    c. August 1: FY Quarter 3 (April – June)
    d. November 1: FY Quarter 4 (July – September)
3. Reporting shall be submitted to the MSHN Customer Service & Rights Manager

B. **MDHHS Medicaid Appeals Reporting**

1. The MDHHS reporting template shall be completed in its entirety prior to submission of the report data and must include any Appeals detail information that closed during the reporting quarter.
2. The data submission is based upon quarterly data within the fiscal year (FY) and is due by the 1st of the second month following the end of each quarter on the following dates:
    1 February 1: FY Quarter 1 (September – December)
    2 May 1: FY Quarter 2 (January – March)
    3 August 1: FY Quarter 3 (April – June)
    4 November 1: FY Quarter 4 (July – September)
3. Reporting shall be submitted to the MSHN Customer Service & Rights Manager

C. **Managed Care Program Annual Report (MCPAR)**

1. The MCPAR report contains appeal and grievance information closed during the reporting fiscal year.
2. The MCPAR report template shall be reviewed, validated, and completed in its entirety prior to submission to MSHN.
3. The data submission is due to MSHN on the 7th of January, following the end of the fiscal year.
4. Report data shall be submitted to the MSHN Customer Service & Rights Manager.

D. **Medicaid Fair Hearings Report**

1. Each report shall be documented on the Medicaid Fair Hearings Report (Exhibit 2). The required reporting includes:
    a. Pre-Paid Inpatient Health Plan (PIHP) or CMHSP Participant Name;
    b. County;
    c. Provider Name;
    d. Number of Requests for Hearing During the Reporting Period;
    e. Number of Hearings Held During the Reporting Period;
    f. Number of Hearings Held During the Reporting Period that Resulted in Favor of Consumer;
    g. Number of Hearings Held During the Reporting Period that Resulted in Favor of CMHSP Participant or PIHP;
    h. Number of Orders of Dismissal Received from MAHS During the Reporting Period;
    i. Number of Hearings Held During the Reporting Period Due to Suspension of Services;
    j. Number of Hearings Held During the Reporting Period Due to Reduction of Services;
    k. Number of Hearings Held During the Reporting Period Due to Termination of Services;
    l. Number of Hearings Held During the Reporting Period Due to Denial of Services;

m. Number of Hearings Held During the Reporting Period Due to Admin. Discharge (Relevant to SUD); and
n. Total

2. The documentation shall be complete in its entirety prior to submission of report
3. The Medicaid Fair Hearings Report is required to be submitted to MSHN semi-annually on the following dates:
   a. January 31: April 1 – September 30 data
   b. July 31: October 1 – March 31 data
4. Reporting shall be submitted to the MSHN Customer Service & Rights Manager

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:

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

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.
b. Reduction, suspension, or termination of a previously authorized service.
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.
d. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.
e. Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization.
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.
g. Failure of the PIHP to act within 30 calendar days from the date of a request for a standard appeal.
h. Failure of the PIHP to act within 72 hours from the date of a request for an expedited appeal.
i. Failure of the PIHP to provide disposition and notice of a local grievance/complaint within 90 calendar days of the date of the request.
j. For a resident of a rural area with only one PIHP, the denial of an enrollee's request to exercise his/her right, to obtain services outside the network.
k. Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibility.

Appeal: A review of an adverse benefit determination
CMHSP: Community Mental Health Service Program
FY: Fiscal Year
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.

IDD: Intellectual Developmental Disability

MCPAR: Managed Care Program Annual Report

MDHHS: Michigan Department of Health and Human Services

Medicaid Services: Services provided to the 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).

MI: Mental Illness

MSHN: Mid-State Health Network

PIHP: Pre-paid Inpatient Health Plan

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.*

SUD: Substance Use Disorders

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

Other Related Materials:

Exhibit 1: MDHHS Medicaid Grievance Reporting Template
Exhibit 2: MDHHS Medicaid Appeals Reporting Template
Exhibit 3: Medicaid Fair Hearings Report Template
Exhibit 4: Recipient Rights Report for Indicator #11 Template

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 attachment: Appeals and Grievances Technical Requirements (P.6.3.1.1)
5. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)

Change Log:

Date of Change	Description of Change	Responsible Party
03.23.2015	New Procedure	A. Horgan
11.21.2016	Annual review, new reporting indicators, and new due dates	Customer Service Committee
12.18.2017	Annual review, definitions updated	Customer Service Committee

12.03.2018	Annual review, new due dates, revised procedure	Customer Service Committee
03.16.2020	Annual review, clarified staff responsible to receive reporting, added reporting template	Customer Service Committee
11.15.2021	Biennial Review, MDHHS reporting requirements update	Customer Service Committee
01.22.2024	Biennial Review, Removed Indicator #11 RR reporting, added MCPAR reporting	Customer Service Committee
01.26.2026	Biennial Review, minor changes	Customer Service Committee