Chapter: 2	Section: 6	Subject: 5

CHAPTER: Board Services and Program Administration		
SECTION: Service Coordination		
SUBJECT: Grievance and Appeal Resolution (Customer Services)		
Administrative Approval:	Date of Governing Board Action: March 16, 1999	Page 1 of 5

I. PURPOSE: To ensure all consumers have access to a fair and efficient process for resolving grievances and appeals.

II. APPLICATION: All mental health programs, services and facilities directly operated by, or under contract with, West Michigan Community Mental Health (WMCMH).

III. REQUIRED BY: Michigan Department of Health and Human Services (MDHHS) Contracts; Prepaid Inpatient Health Plan (PIHP) Contract; Balanced Budget Act; SUD Services Provider Manual; and Accrediting Bodies.

IV. DEFINITIONS:

A. **Adverse Benefit Determination:** A decision that adversely impacts a consumer's claim for services due to denial, reduction, suspension, termination or limited authorization of a service.

B. **Adequate Notice of Adverse Benefit Determination:** Written statement advising the consumer of a decision to deny or limit authorization of services requested, which notice must be provided on the same date the Adverse Benefit Determination takes effect. *42 CFR 438 (c)(2).*

C. **Administrative Tribunal:** The entity charged by the MDHHS with the responsibility for conducting State Fair Hearings.

D. **Advance Notice of Benefit Determination:** Written statement advising the consumer of a decision to reduce, suspend or terminate services currently provided, which notice must be provided/mailed to the individual 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*.

E. **Customer Services Inquiry:** Consumer contact with Customer Services staff for the purpose of requesting information about Community Mental Health Service Provider (CMHSP) services, requesting advocacy, requesting referral to internal/external providers, requesting assistance with completing paperwork, etc.

F. **Date of Action:** The date on which WMCMH proposes to deny, suspend, reduce or terminate a mental health service.

G. **Expedited Appeal**: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a).*

H. **Grievance:** An expression of dissatisfaction about services other than an Adverse Benefit Determination. Possible subject for grievances include but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the individual, failure to respect the individual's rights regardless of whether remedial action is requested, or an individual's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. *42 CFR 438.400.*

I. **Local Appeal:** A review at the local level by a CMHSP or PIHP of an Adverse Benefit Determination, as defined above. A written decision from the CMHSP or PIHP will be provided to the consumer within 30 calendars days after the appeal is received. If the appeal is for payment of a service already rendered, a written decision will be provided within 60 calendar days.

J. **MDHHS Alternative Dispute Resolution Process:** Impartial State level review, presided over by the MDHHS, of an appeal. This process is available to Non-Medicaid consumers, only after the Local Appeals Resolution Process has been exhausted.

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

L. **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.

V. **POLICY:** West Michigan Community Mental Health will provide for a fair and efficient process for resolving consumer complaints (i.e., grievances and appeals) that is compliant with State, Federal and Balanced Budget Act regulations as indicated in the Michigan Department of Health and Human Services (MDHHS) Contracts and Prepaid Inpatient Health Plan (PIHP) Contract. Grievance and Appeals will be coordinated through the Office of Customer Services.

VI. **PROCEDURES:** All grievances and appeals received by West Michigan Community Mental Health will be resolved following the processes outlined in the "Grievance and Appeal Technical Requirement – PIHP Grievance System for Medicaid Beneficiaries" document and the "CMHSP Local Dispute Resolution Process" document (Attachment #7). Substance Use Disorder treatment services provided by the SUD Provider Network also follow the same process. *(Note: Grievances and appeals filed by Non-Medicaid consumers will be resolved utilizing the processes outlined in the "CMHSP Local Dispute Resolution Process" document. Grievances and appeals filed by Medicaid consumers (including requests for expedited appeals) will be resolved utilizing the processes outlined in the "Grievance and Appeal Technical Requirement – PIHP Grievance System for Medicaid Beneficiaries" document.)*

In the event a consumer requests a second opinion, in addition to the following the resolution processes outlined in the "Grievance and Appeal Technical Requirement – PIHP Grievance System for Medicaid Beneficiaries" document and the "CMHSP Local Dispute Resolution Process" document (Attachment #1), WMCMH will also follow all second opinion resolution processes (Attachment #5) identified in the Michigan Mental Health Code, MCL 300.1705, and the Code of Federal Regulations, 42CFR438.206(b)(3).

In the event the above-mentioned technical requirement documents are revised, West Michigan Community Mental Health will evaluate current grievance and appeals resolution processes for compliance to these documents and will make revision to the WMCMH grievance and appeal processes as needed.

Customer Services contact notes and communications between Customer Services staff and WMCMH staff relative to a complaint are peer review documents. Unauthorized release or duplication of these documents is prohibited.

The specific forms and procedures for management of grievance and appeals issues are delineated in the following documents and flow charts.

Organizational Processes and Flow Charts

Attachment 1	Customer Services Receives Call Flowchart
Attachment 2	Customer Services Inquiry Process Flowchart
Attachment 3	Faith Hearing Process Flowchart
Attachment 4	MDHHS Alternative Dispute Resolution Process Flowchart
Attachment 5	Second Opinion Process Flowchart

Forms

Attachment 6 Notice of Adverse Benefit Determination

Technical Requirement Documents

Attachment 7 -- MDHHS/CMHSP Managed Mental Health Supports and Services – Amendment #1 – Attachment C6.3.2.1
-- Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program – Amendment #2 – Attachment P6.3.2.1

Plan-Specific Procedures for Administration of Advanced and Adequate Notice

Attachment 8 NABD – Service Entry
Attachment 9 NABD – Preadmission Screening
Attachment 10 NABD – Family Support Subsidy
Attachment 11 NABD – Person-Centered Plans
Attachment 12 NABD – Transition/Discharge Plan with Active Authorizations
Attachment 13 NABD – Transition/Discharge Plan with Inactive Authorizations
Attachment 14 NABD – WMCMH Initiated Service Discontinuation/Reduction

X. SUPPORTING DOCUMENTS:

Appendix 2-6-5A: PA 516 of 1996 – Right to File a Grievance
Appendix 2-6-5B: 42 CFR Chapter IV.E.431.200 et seq – Fair Hearings for Applicants and Recipients

House Bill 5571 (1996)

Public Act 516 of 1996 (Effective: 10/01/97) Find this PA in the MCL

Sponsors Laura Baird - (primary)
Mary Schroer , John Freeman , Kirk Profit , Sue Rocca , Michael Griffin , David Anthony , Sharon Gire , David Gubow , Liz Brater , Deborah Cherry , Maxine Berman , Jack Horton , Jan Dolan , Alvin Kukuk , John Jamian , Jon Jellema , Michael Goschka , Penny Crissman , Sandra Hill , Clark Harder , Timothy Walberg , John Gernaat , Dan Gustafson , Candace Curtis , Eileen DeHart , Gregory Pitoniak , Tracey Yokich , Paul Baade , Lloyd Weeks , Clyde LeTarte , Mike Green , Kim Rhead , Michelle McManus , Frank Fitzgerald , Tom Alley , Lyn Bankes , Allen Lowe , David Galloway , Thomas Middleton , Beverly Bodem , John Llewellyn , Howard Wetters , Curtis Hertel , James Agee , Michael Bennane , Robert Brackenridge , Lingg Brewer , Eric Bush , William Byl , Nick Ciaramitaro , Floyd Clack , Alan Cropsey , Jessie Dalman , Walter DeLange , Robert DeMars , Barbara Dobb , Agnes Dobronski , Bob Emerson , Pat Gagliardi , Terry Geiger , Donald Gilmer , Carl Gnodtke , Beverly Hammerstrom , Michael Hanley , Roland Jersevic , Thomas Kelly , Carolyn Cheeks Kilpatrick , Edward LaForge , Terry London , Lynne Martinez , Thomas Mathieu , Jim McBryde , James McNutt , James Middaugh , Raymond Murphy , Michael Nye , Dennis Olshove , Lynn Owen , Glenn Oxender , Joseph Palamara , Mary Lou Parks , Charles Perricone , Vincent Porreca , Hubert Price Jr., Michael Prusi , Gary Randall , James Ryan , Martha Scott , Ken Sikkema , Paul Tesanovich , Ilona Varga , Ed Vaughn , Harold Voorhees , Ted Wallace , Deborah Whyman , Karen Willard

Categories Insurance, health care corporations; Insurance, insurers

Insurance; health care corporations; guaranteed renewal, description of certificate, limits on exclusions for preexisting conditions, and grievance procedures; provide for and provide for other general amendments. Amends sec. 404 of Act 350 of 1980 (MCL 550.1404) & adds secs. 401e, 402a & 402b.

Section 550.1404

THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)
Act 350 of 1980

550.1404 Violation of MCL 550.1402 or MCL 550.1403; private informal managerial-level conference; review by commissioner; internal procedures; determination by commissioner; expedited grievance procedure; procedural rules; hearing matter as contested case; authorization to act on behalf of member.

Sec. 404.

(1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, is entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 before an independent review organization under the patient's right to independent review act, if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). These procedures shall provide all of the following:

(a) That a final determination will be made in writing by the health care corporation not later than 35 calendar days after a grievance is submitted in writing by the member. The timing for the 35-calendar-day period may be tolled, however, for any period of time the member is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 days if the health care corporation has not received requested information from a health provider.

(b) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(c) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(d) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the member along with written notifications as required under the patient's right to independent review act.

(e) A method for providing summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person is entitled to a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act.

(4) A health care corporation shall establish, as part of its internal procedures, an expedited grievance procedure. The expedited grievance procedure shall provide that a determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. Within 10 days after receipt of a determination, the member may request a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act. If the determination by the health care corporation is made orally, the health care corporation shall provide a written confirmation of the determination to the member not later than 2 business days after the oral determination. An expedited grievance under this subsection applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subsections (1) to (3) would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. This subsection does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. As used in this section, “grievance” means an oral or written statement, by a member to the health care corporation that the health care corporation has wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.

(5) The commissioner shall by rule establish a procedure for determination under this

section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

(7) A member may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

History: 1980, Act 350, Eff. Apr. 3, 1981;-- Am. 1996, Act 516, Eff. Oct. 1, 1997;-- Am. 2000, Act 250, Imd. Eff. June 29, 2000
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

Code of Federal Regulations]
[Title 42, Volume 3]
[Revised as of October 1, 2004]
From the U.S. Government Printing Office via GPO Access
[**CITE: 42CFR431.200**]

[Page 35]

TITLE 42--PUBLIC HEATLH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 431_STATE ORGANIZATION AND GENERAL ADMINISTRATION--Table of Contents

Subpart E_Fair Hearings for Applicants and Recipients

Source: 44 FR 17932, Mar. 29, 1979, unless otherwise noted.

General Provisions

This subpart--

(a) Implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly;

(b) Prescribes procedures for an opportunity for a hearing if the State agency or PAHP takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and

(c) Implements sections 1919(f)(3) and 1919(e)(7)(F) of the Act by providing an appeals process for any person who--

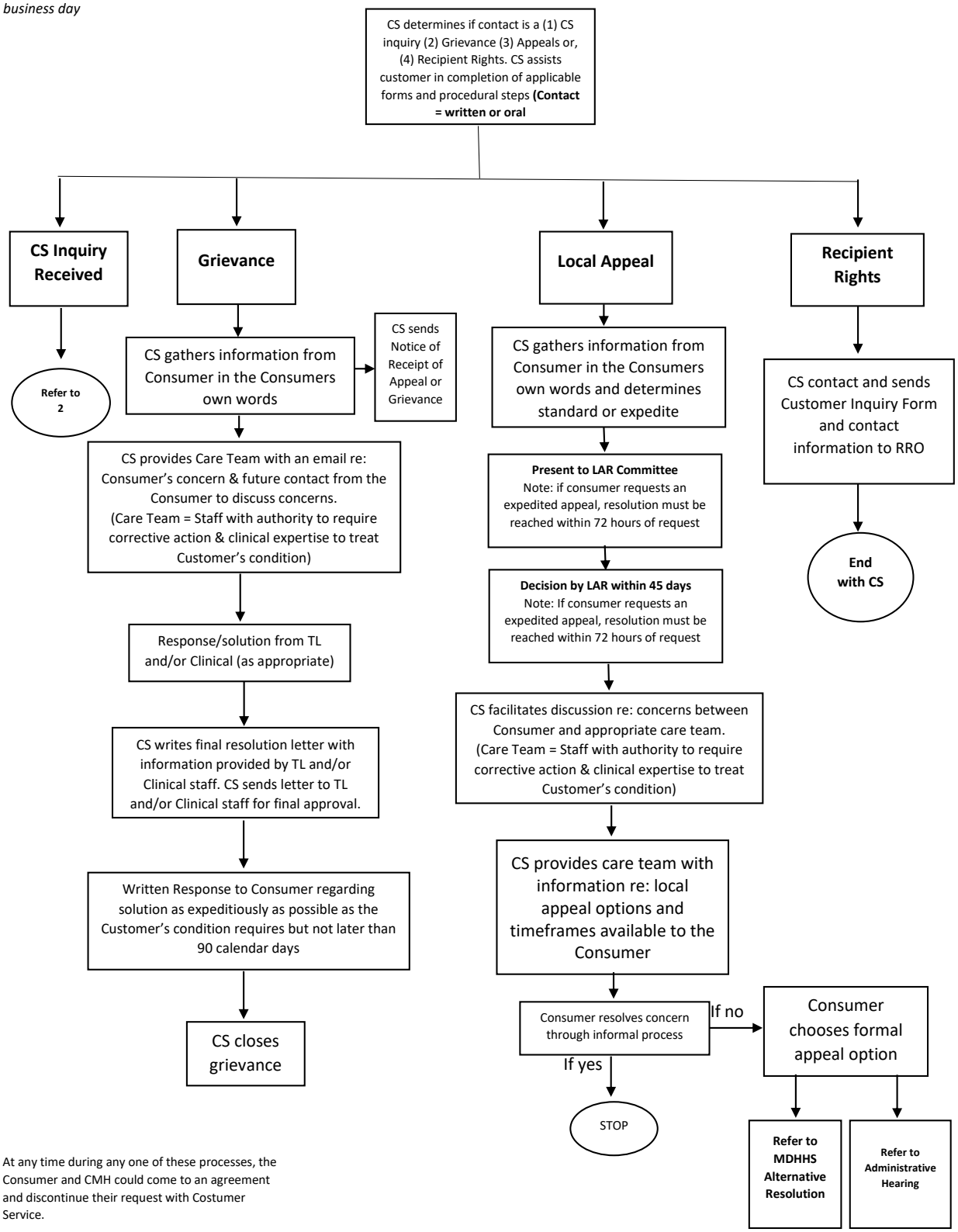
1. Is subject to a proposed transfer or discharge from a nursing home facility; or
2. Is adversely affected by the pre-admission screening or the annual resident review that are required by section 1919(e)(7) of the Act.

[67 FR 41094, June 14, 2002]

**Note: All urgent calls returned the same day and other returned within 1 business day*

CUSTOMER SERVICE RECEIVES A CALL*
Updated 09/2019

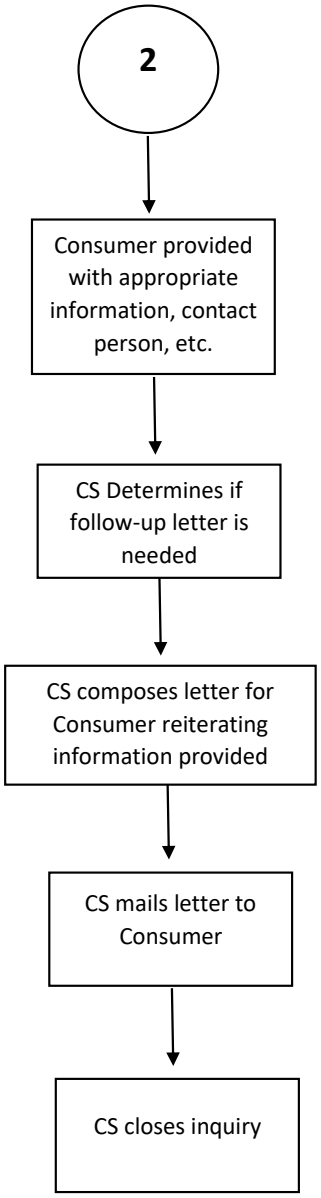
Attachment #1



At any time during any one of these processes, the Consumer and CMH could come to an agreement and discontinue their request with Costumer Service.

Attachment #2

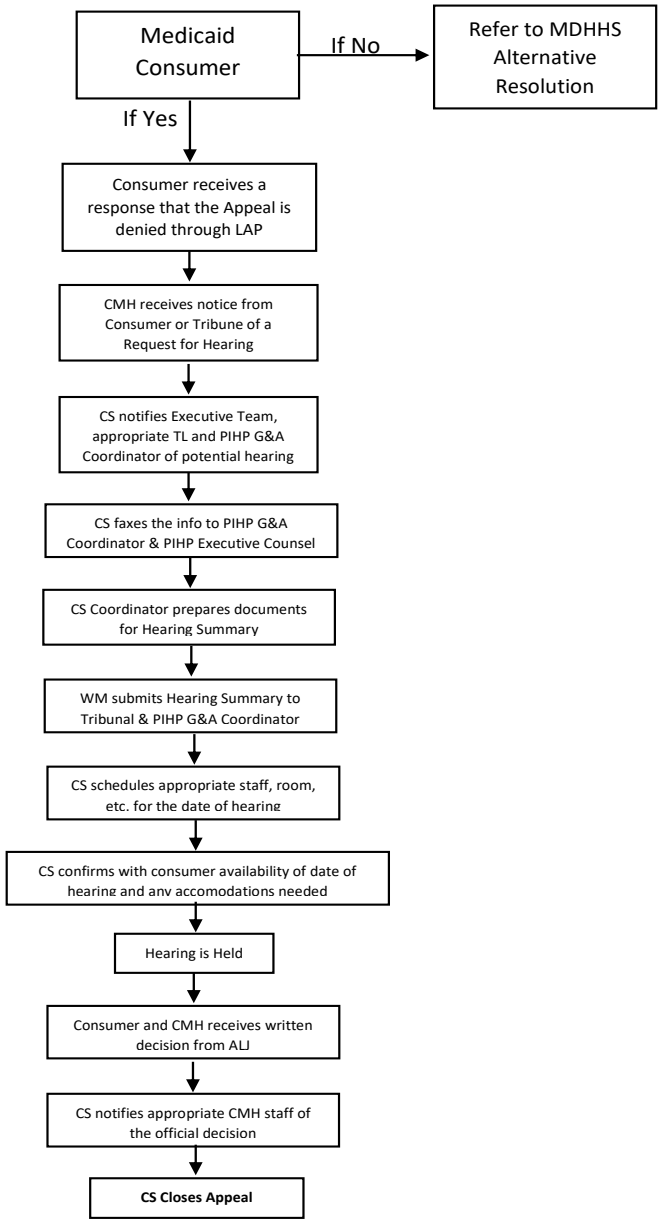
CUSTOMER SERVICE INQUIRY
Updated 09/2019



At any time during any one of these processes, the Consumer and CMH could come to an agreement and discontinue their request with Costumer Service.

Attachment #3

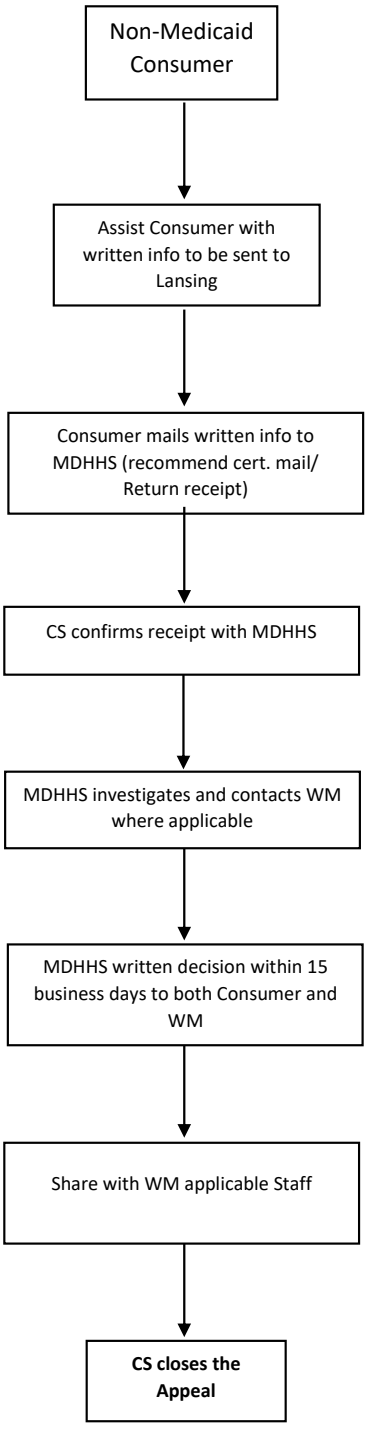
FAIR HEARING
(Medicaid Consumers Only or Grievance)
Updated 09/2019



Note: At any time during any one of these processes, the Consumer and CMH could come to an agreement and discontinue their request with Customer Service.

Attachment #4

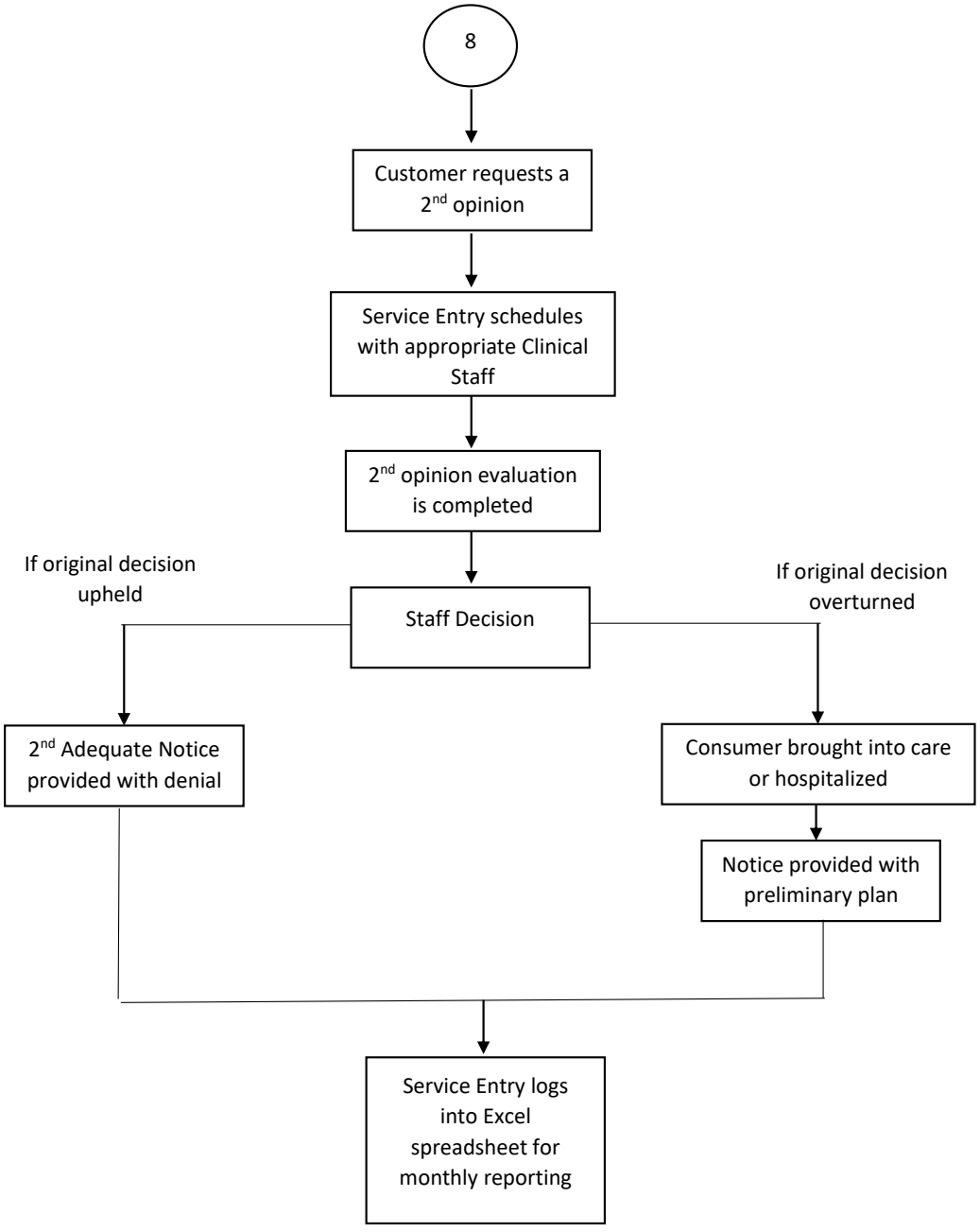
MDHHS ALTERNATIVE RESOLUTION
(NON-MEDICAID CONSUMERS ONLY)
Updated 09/2019



Note: At any time during any one of these processes, the Consumer and CMH could come to an agreement and discontinue their request with Customer Service

Attachment # 5

SECOND OPINION
Updated 09/2019



At any time during any one of these processes, the Consumer and CMH could come to an agreement and discontinue their request with Costumer Service.

Attachment 6

Lake County
1090 N. Michigan Ave.
Baldwin, MI 49304
(231) 745-4659
FAX (231) 845-7095

Mason County
920 Diana St.
Ludington, MI 49431
(231) 845-6294
FAX (231) 845-7095

Oceana County
105 Lincoln
Hart, MI 49420
(231) 873-2108
FAX (231) 845-7095

NOTICE OF ADVERSE BENEFIT DETERMINATION

Date: <Mailing Date>

CMHOC ID: <Case ID Number>

Name: <Member's Name>
<Address>

Medicaid ID: <Medicaid ID Number>

This is to tell you that the following action has been taken:

_____

_____

The action is based on the following:

_____

_____

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our action, you have the right to an Internal Appeal
You have to ask West Michigan Community Mental Health (WMCMH) for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other informatin that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:
Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already

received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

West Michigan Community Mental Health
Attn: Customer Services
920 Diana St.
Ludington, MI 49431
Phone: 231-845-6294
TTY: 800-790-8326
Fax: 231-845-7095

Expedited or Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request**. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: **800-992-2061**

Continuation of services during an Internal Appeal
If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending and should submit your request to West Michigan Community Mental Health.

> Your benefits for that service will continue if you request and internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

If you want someone else to act for you
You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **231-845-6294** to learn how to name your representative. TTY users call **800-790-8326**. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Access to Documents
You and your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.

- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

Get help & more information

- WMCMH: If you need help or additional information about our decision and the internal appeal process, call Member Services at: **231-845-6294; TTY: 800-790-8326** Monday through Friday, 8am to 5pm. You can also visit our website at www.wmcmhs.org
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line; 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability.

Non-Discrimination and Accessibility Notice

West Michigan Community Mental Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. West Michigan Community Mental Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

West Michigan Community Mental provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-800-992-2061.

If you believe West Michigan Community Mental Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Customer Services Department:

West Michigan Community Mental Health
Customer Services Department
920 Diana Street
Ludington, MI 49431

1-800-992-2061
TTY: 1-800-790-8326
FAX: 1-231-845-7095

You can file a grievance by mail, fax or email. If you need help in filing a grievance, our Complaints and Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attachment # 7

GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT
PIHP GRIEVANCE AND APPEAL SYSTEM FOR MEDICAID BENEFICIARIES OCT. 2017

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the Medicaid Enrollee Grievance and Appeal System requirements contained in Part 11, 6.3.1 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance and Appeal System processes required for Medicaid Enrollees, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Consumers of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- PIHP appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.).
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705).

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Adverse Benefit Determination: A decision that adversely impacts a 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 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 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).*
- 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).*

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.

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: Enrollee'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 Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an 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 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, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

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.*

Recipient Rights Complaint: Written or verbal statement by a 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.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee's that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

- An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance Process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
- The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
- With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

A PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a).*

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements: *(42 CFR 438.404(a)-(b))*

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

2. 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;

3. Description of Adverse Benefit Determination;

4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;

5. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;

7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;

8. 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 (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and

10. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

B. Timing of Notice: *(42 CFR 438.404(c))*

1. Adequate Notice of Adverse Benefit Determination:

   a. For a 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. *42 CFR 438.404(c)(2).*

   b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-

hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

c. For Service Authorization decisions not reached within 14-days for 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. *42 CFR 438.404(c)(5).*

- NOTE, however, that 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 calendar days if either the Enrollee requests the extension, or if the PIHP can show that there is a need for additional information and that the extension is in the Enrollee's best interest *(42 CFR 438.210(d)(1)(ii)).* If the PIHP extends the time <u>not</u> at the request of the Enrollee, the PIHP must: (i) make reasonable efforts to give the Enrollee prompt oral notice of the delay; (ii) within 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 or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*

2. <u>Advance Notice of Adverse Benefit Determination:</u>

a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.

b. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date**.** *42 CFR 438.404(c)(1); 42 CFR 431.211.*

c. <u>Limited Exceptions</u>: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF *(42 CFR 431.213; 42 CFR 431.214)*

i. The PIHP has factual information confirming the death of an Enrollee;

ii. The PIHP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;

iii. The Enrollee has been admitted to an institution where he is ineligible under the plan for further services;

iv. The Enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;

v. The PIHP establishes that the Enrollee 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 Enrollee's physician;

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. The date of 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 Enrollee (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*

2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. *42 CFR 438.210(c).*

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

1. The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii);*

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated B**e**nefits *(42 CFR 438.420(c)*)**.** If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The Enrollee withdraws the Appeal or request for State Fair Hearing;

2. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;

3. A State Fair Hearing office issues a decision adverse to the Enrollee.

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d)*.

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a).*

VI. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii).*

2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii).*

NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3).*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

B. PIHP Responsibilities when Enrollee Requests an Appeal:

1. Provide Enrollees reasonable assistance to complete forms and to take other 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. *42 CFR 438.406(a).*

2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1).*

3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416.*

4. Ensure that the individual(s) who make the decisions on Appeals: *42* CFR 438.406(b)(2).

   a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

   b. 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, as determined by the State, in treating the Enrollee's condition or disease.

c. Take into account 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.

5. Provide the Enrollee 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 sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4).*

6. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5).*

7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6*).

8. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal.

2. Expedited Appeal Resolution (timing):

a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that 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. *42 CFR 438.410(a).*

b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42 CFR 438.410(b).*

c. If a request for expedited resolution is denied, the PIHP must:

i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1).

ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2)*.

iii. Within 2-calendar days, give 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 they disagree with the decision**.** *42 CFR 438.408(c)(2), 438.410(c)(2).*

iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.

d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408*.

3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give 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 they disagree with the decision.

iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

4. Appeal Resolution Notice Format:

   a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*

   b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse Benefit Determination", Exhibit B "Notice of Receipt of Appeal/Grievance", Exhibit C Notice of Appeal Approval", and Exhibit D "Notice of Appeal Denial". These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

      (1) A general description of the reason for the appeal or grievance.
      (2) The date received.
      (3) The date of each review or, if applicable, review meeting.
      (4) Resolution at each level of the appeal or grievance if applicable.
      (5) Date of resolution at each level, if applicable.
      (6) Name of the covered person for whom the appeal or grievance was filed.

      Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

   c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: *42 CFR 438.408(e)*

   a. The notice of resolution must include the results of the resolution and the date it was completed.

   b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:

      i. Right to request a state fair hearing, and how to do so;

ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

VII. GRIEVANCE PROCESS

A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. *(42 CFR 438.228)*

B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i)*.

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination," and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other 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. *42 CFR 438.406(a).*

2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1).*

3. Maintain a record of grievances for review by the State as part of its quality strategy.

4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*

5. Ensure that the individual(s) who make the decisions on the Grievance:

a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i).*

b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

c. Take into account 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

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.

2. Extension of Timeframes: The PIHP may extend the grievance resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

    a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

        i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

        ii. Within 2-calendar days, give 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 they disagree with the decision; and

        iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

3. Format and Content of Notice of Grievance Resolution:

    a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

    b. The notice of Grievance resolution must include:

i. The results of the Grievance process;
ii. The date the Grievance process was concluded; iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
iii. Instructions on how to access the State Fair Hearing process, if applicable.

VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1);*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

C. The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

D. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2).*

E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

F. 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.

G. The parties to the State Fair Hearing include the PIHP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html OR

Department of Licensing and Regulatory Affairs Michigan
Administrative Hearing System Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

IX. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A PIHP's record of each Grievance or Appeal must contain, at a minimum:

A. 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. The date of the resolution at each level, if applicable;
F. Name of the covered person for whom the Grievance or Appeal was filed.

PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

X. RECIPIENT RIGHTS COMPLAINT PROCESS

Enrollees, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

Exhibit A

NOTICE OF ADVERSE BENEFIT DETERMINATION
<Health Plan/CMHSP-PIHP name/ MI Choice Waiver Agency name>

Important: This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This is to tell you that the following action has been taken:

_____

_____

[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]

This action is based on the following:

_____

_____

[*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our action, you have the right to an Internal Appeal

You have to ask <Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name> for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

<Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name>
Address
Phone Number TTY Phone Number Fax Number

Expedited or Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: {**Phone Number} {TTY Phone #}**

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: <number(s)> to learn how to name your representative. TTY users call <number>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
- [*Licensed health plans in Michigan must also insert*: You can also ask for an External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).]
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability waiver resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

Exhibit B

Notice of Receipt of Appeal/Grievance
<Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name>

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

Mailing Date: <Mailing Date> **Member ID:** <Member's Plan ID Number>

Name: <Member's Name> **Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to a request that we received on <date received>.

We received your grievance on <date received> about <subject of grievance>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

WHAT THIS MEANS

We will review your grievance by <date received plus 90 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take or have taken.

You Filed An Internal Appeal

We received your request for an internal appeal on <date received>. You are appealing our decision to <description of subject of appeal>.

WHAT THIS MEANS

A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.

<The appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the appeal is being reviewed.> You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

We may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call <list an appeals specific phone number/fax number>.

FOR BOTH GRIEVANCES AND APPEALS If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

Get help & more information

- {Health plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

Exhibit C

Notice of Appeal Approval
<Health Plan/CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains the results of your appeal. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date> **Member ID:** <Member's Plan ID Number>

Name: <Member's Name> **Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>

Your appeal was approved

Your appeal was thoroughly considered. This is to inform you that we approved your appeal for the service/item listed below:

What this means:

Because your Level 1 Appeal decision was approved, you may receive the following services as of <date authorized>: [*List the services that were approved, including any applicable information about coverage amount, duration, etc. Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

If you do not receive the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:

<Health Plan / CMHSP-PIHP / MI Choice Wavier Agency name>

<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>
Phone: <phone number> TTY: <TTY number>
Fax: <fax number>

Getting your case file

You can ask to see the medical records and other documents we reviewed during your appeal. You can also ask for a copy of the guidelines we used to make our decision. You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

Exhibit D

Notice of Appeal Denial
<Health Plan/ CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains your additional appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>.

Your internal appeal was denied

Your appeal was thoroughly considered. This is to inform you that we [*denied* or *partially denied*] your internal appeal for the service/item listed below:

_____

_____

Why did we deny your appeal?

We [*denied* or *partially denied*] your internal appeal for the service/item listed above because:
[*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]
You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our decision, you have the right to further appeal

You have the right to an External Appeal. The External Appeal is reviewed by an independent organization that is not connected to us. You can file an External Appeal yourself.

[*Health plans must insert:* There are two ways to make an External Appeal: 1) State Fair Hearing with the Michigan Administrative Hearing System (MAHS) and/or 2) External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial
Services (DIFS).] [*PIHP and MI Choice Waiver Agency must insert:* You can do this by asking for a State Fair Hearing with the Michigan Administrative Hearing System (MAHS).]

Below is information on how to request a State Fair Hearing with MAHS [*Health Plans must insert:* and an External Review with DIFS].

How to ask for a State Fair Hearing with MAHS

To ask for a Medicaid State Fair Hearing you must follow the directions on the enclosed Request for State Fair Hearing form. You must ask for a State Fair Hearing within **120 calendar days** from the mailing date of this notice. If your request is not received at MAHS by <insert 120 calendar day date>, you will not be granted a hearing. If you need another copy of the form, you can ask for one by calling <Health Plan/ CMHSP-PIHP/ MI Choice Waiver Agency name> Member Services at <phone number> or the Michigan Department of Health and Human Services Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

What happens next?

MAHS will schedule a hearing. You will get a written "Notice of Hearing" telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person. During the hearing, you'll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) State Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MAHS (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the State Fair Hearings process, including the fast State Fair Hearing, you can call MAHS at 1-877-833-0870.

[*PIHP and MI Choice are not subject to PRIRA and should therefore delete the following section on filing with DIFS.*]

How to ask for an External Review with DIFS

To ask for an External Review under the Patient Right to Independent Review Act (PRIRA) from DIFS, you must complete the Health Care Request for External Review form. The form is included with this notice. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to the address or fax number listed on the form. You must submit your request within **60 calendar days** of your receipt of this appeal decision notice. You have the right to request and receive benefits while the hearing is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

What happens next?

DIFS will review your request. If your case does not require medical record review, DIFS will issue a decision within 14 calendar days after your request is accepted. If your case involves issues of medical necessity or clinical review criteria, DIFS will issue a decision within 21 calendar days.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) External Review. To ask for a fast External Review, you can call DIFS at 1-877-999-6442. A fast External Review is completed within 72 hours after your request has been accepted.

Continuation of Services

If we previously approved coverage for a service but then decided to change or stop the service before the authorization ended, you can continue your benefits during External Appeals in some cases.

Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

If your benefits are continued during your appeal, you can keep getting the service until one of the following happens: 1) you withdraw the External Appeal; or 2) all entities that got your appeal decide “no” to your request.

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

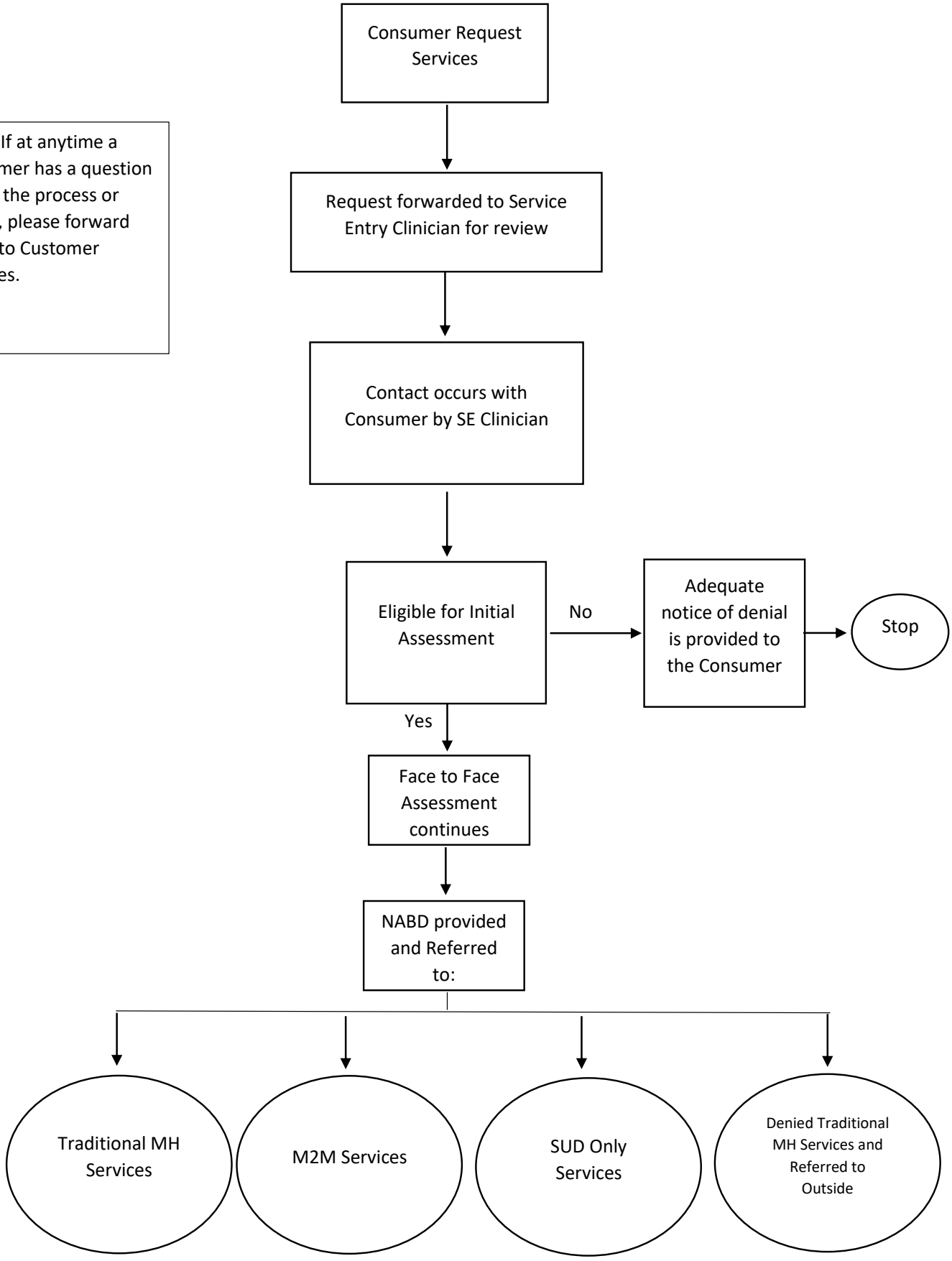
- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

Attachment # 8

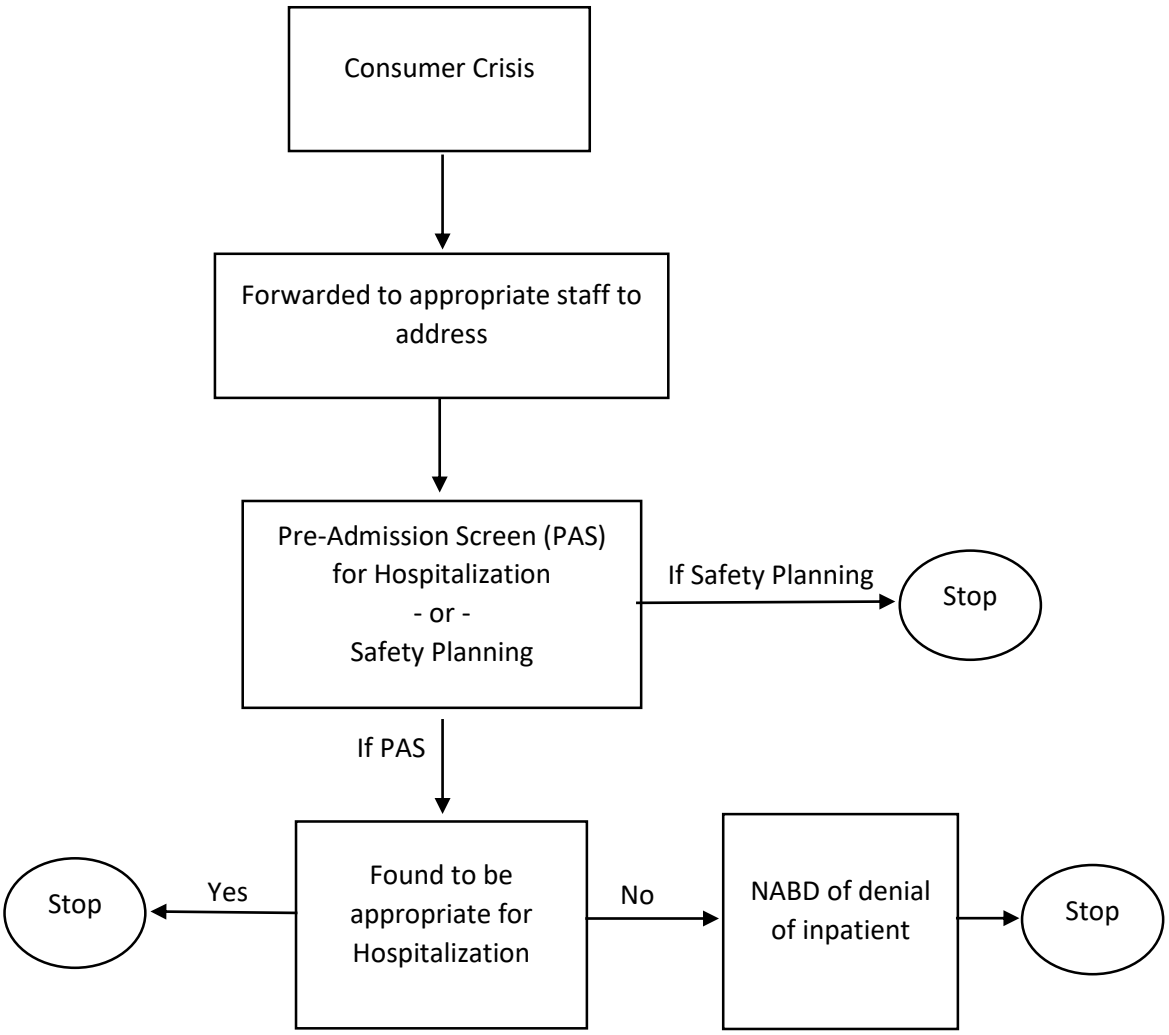
NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD)
Service Entry
Updated 09/2019

Note: If at anytime a Customer has a question about the process or forms, please forward them to Customer services.



Attachment # 9

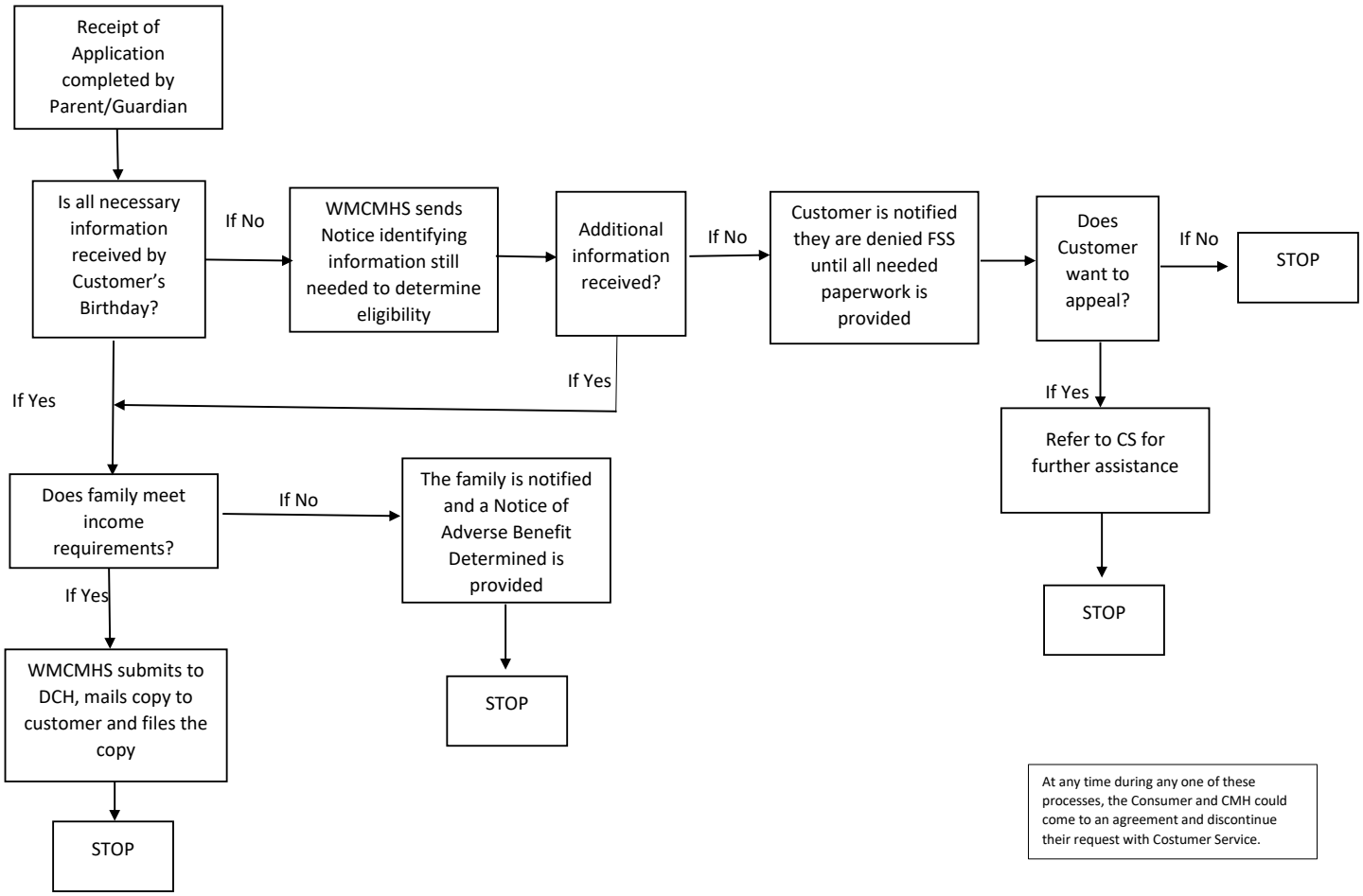
NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD)
PAS
Updated 09/2019



Note: If at anytime a Customer has a question about the process or forms, please forward them to Customer services.

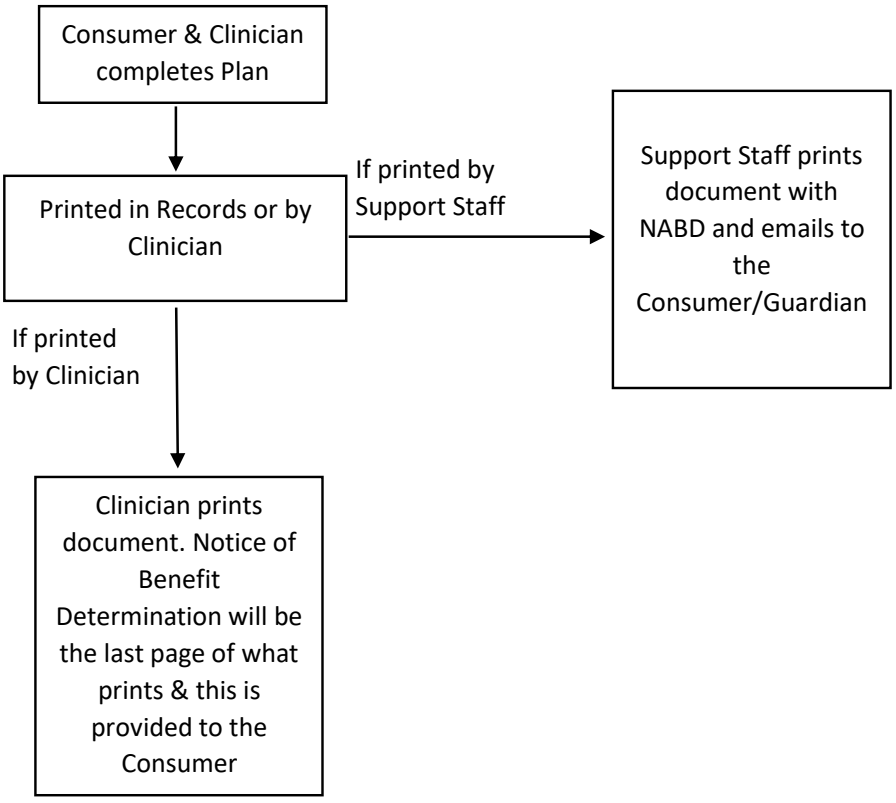
Attachment # 10

NOTICE of ADVERSE BENEFIT DETERMINATION
FAMILY SUPPORT SUBSIDY
UPDATED 09/2019



Attachment # 11

NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD)
Person Centered Plan, SE Preliminary Plan/Assessment, PCP Review,
Inpatient Transition & SUD Treatment Plan
(Clinician & Support Staff)
Updated 09/2019

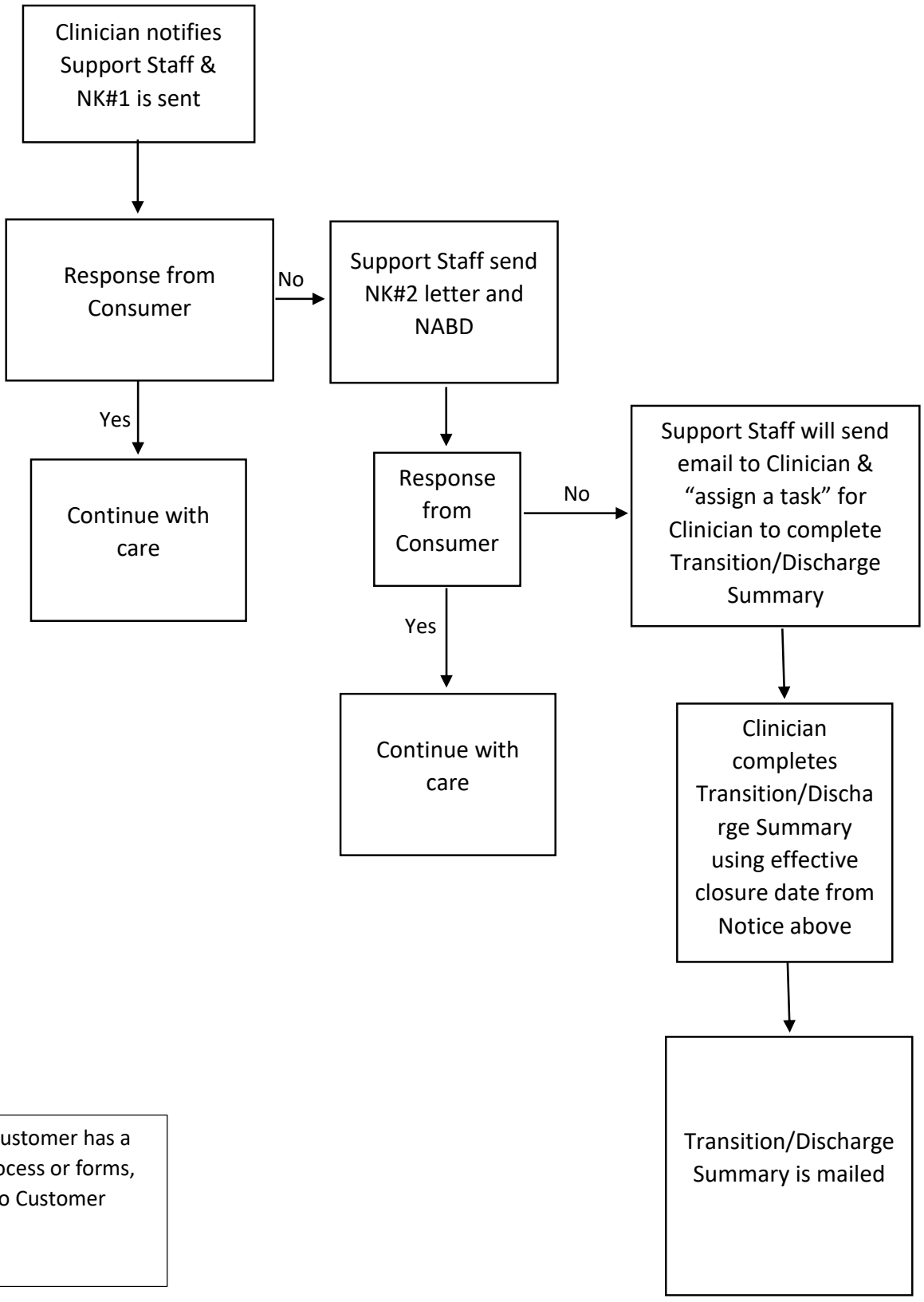


Note: If at anytime a Customer has a question about the process or forms, please forward them to Customer services.

One copy of the notice will print with the PCP document. If mailed, the PCP document and adequate notice will be accompanied by a letter. A copy of the system generated notice is in ECR and also a copy of the letter that was mailed to the Consumer. The letter will be a related document to the system generated notice, and the date of the letter equals the notice date.

Attachment # 12

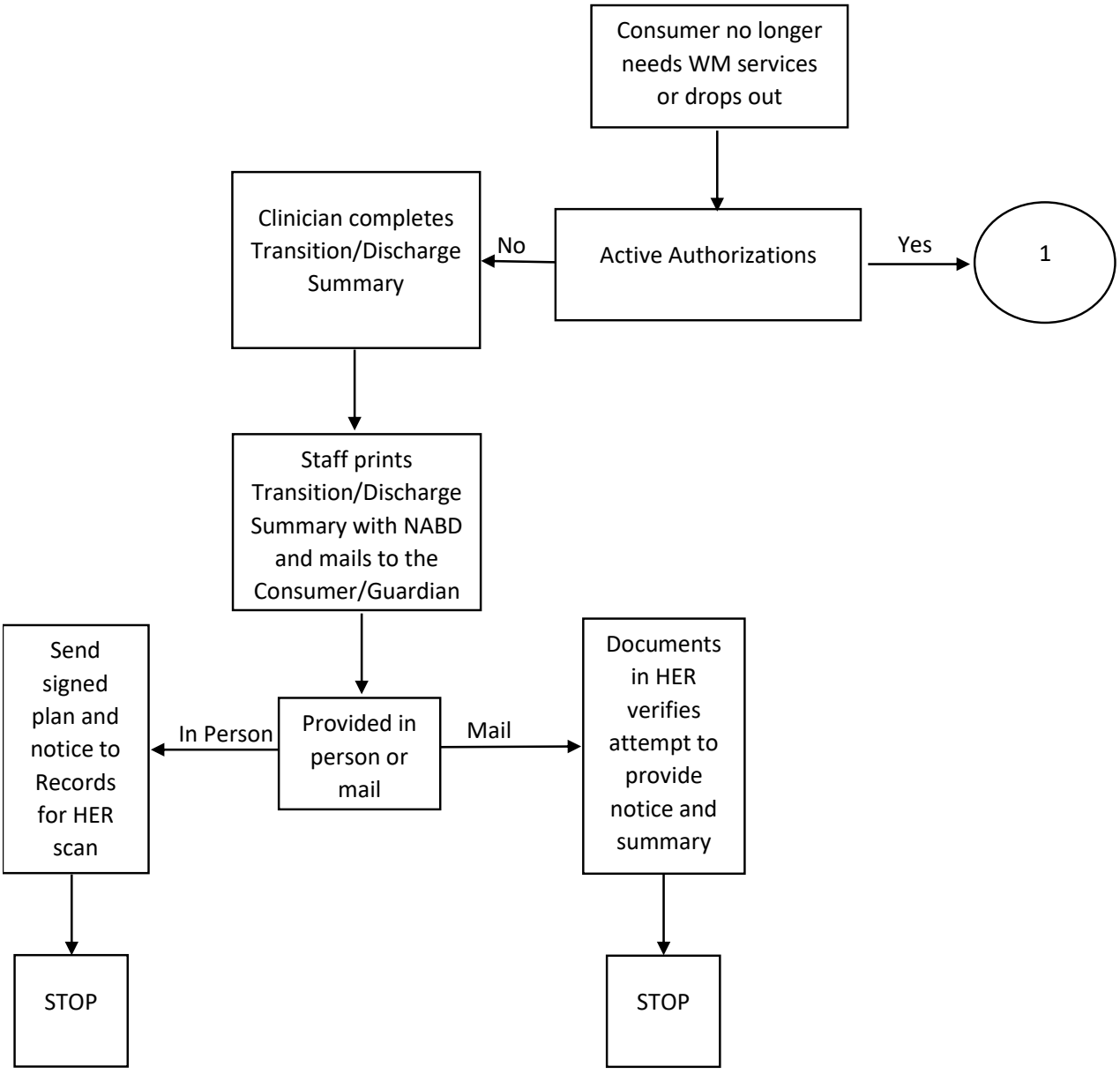
NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD)
Transition/Discharge Summary with Active Authorizations
Updated 09/2019



Note: If at anytime a Customer has a question about the process or forms, please forward them to Customer services.

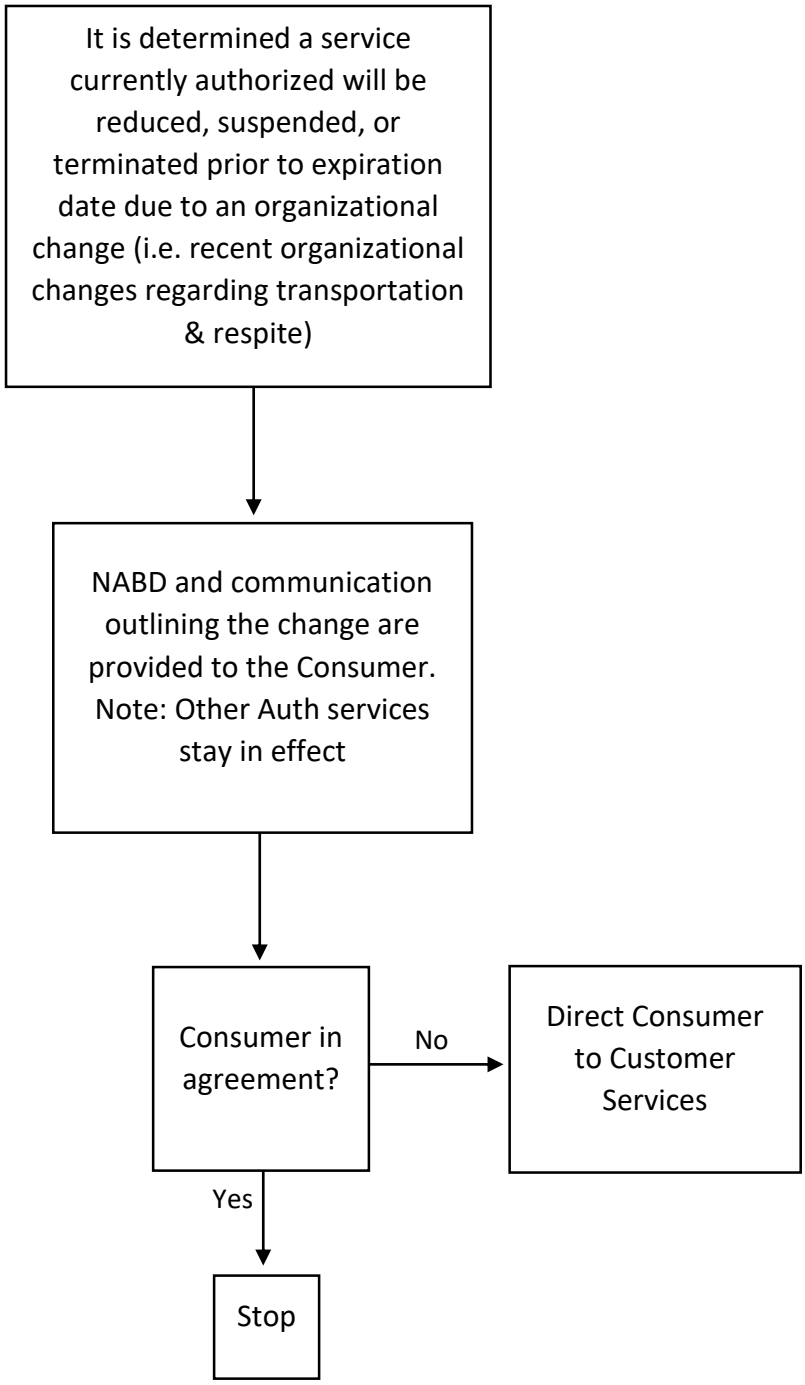
Attachment # 13

NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD)
Transition/Discharge Summary with No Active Authorizations
Updated 09/2019



Note: If at anytime a Customer has a question about the process or forms, please forward them to Customer services.

NOTICE OF ADVERSE BENEFIT DETERMINATION (NABD)
WMCMH Initiated Service Discontinuation/Reduction
Updated 09/2019



Note: If at anytime a Customer has a question about the process or forms, please forward them to Customer services.