Issue Date: 9/14

Review and/or Revision Date: 3/16,4/16,8/18, 3/2022

SUBJECT	CHAPTER	SECTION	SUBJECT
Grievance and Appeal System	07	02	01

CHAPTER	SECTION
Rights of Persons Served	Grievances and Appeals

WRITTEN BY	REVIEWED BY	AUTHORIZED BY
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I. APPLICATION:

☐ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It is the policy of Region 10 PIHP that a grievance and appeal system will be established and maintained and in compliance with state and federal regulations, in order to ensure all Medicaid Enrollees the right to a fair and efficient process for resolving disagreements regarding their services and supports. An individual of, or applicant for, public mental health services may access several options to pursue the resolution of disagreements. This system includes both mental health and substance use disorder services and treatments. It is the policy of Region 10 PIHP to follow all state and federal regulations regarding the resolution of complaints and disputes individuals may have about their services and supports.

This policy and any corresponding policies in no way requires the enrollee to utilize the grievance or appeal process prior to the filing of a recipient rights compliant pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and affiliate policies relative to the filing of Recipient Rights Complaints. This is also true for the Recipient Rights process for Substance Use Disorder services.

III. DEFINITIONS:

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an "access center", where Medicaid beneficiaries call or go to request behavioral health services.

Adverse Benefit Determination: A decision that adversely impacts an enrollee's claim for services due to:

- 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
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- 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 authorization.

- Failure to make an expedited authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization
- Failure to provide service within **14 calendar days** of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP
- 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
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request
- For a resident of a rural area with only one Managed Care Organization (MCO), the denial of an Enrollees request to exercise his/her right, under 438.52 (b)(2)(ii), and to obtain services outside the network
- Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibilities.

Adequate Adverse Benefit Determination Notice: Written statement advising the Enrollee of a decision to deny or limit the authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect.

Advance Adverse Benefit Determination Notice: Written statement advising the Enrollee of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination takes effect.
Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination.

Applicant: A person, or his/her legal representative, who makes a request for mental health or substance use disorder services.

Authorization of Services: For the processing of requests for initial and continuing authorization of services.

Beneficiary: An individual who is eligible for an enrolled in the Medicaid program in Michigan.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid Enrollees, and all other recipients of PIHP/CMHSP services.

Enrollee: A Medicaid recipient who is currently enrolled in a PIHP in a given managed care program.

Expedited Appeal: For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the PIHP receives the appeal.

Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness or a provider or employee, or failure to respect beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP to make an authorization decision.

Grievance Process: Impartial local review of an Enrollee's Grievance.

Grievance and Appeal System: The processes the PIHP implements to handle the Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them.

Hearing Officer: Staff person assigned to represent the PIHP at a State Fair Hearing

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 (SSA).

Mental Health Professional: A person who is trained and experienced in the area of mental illness or intellectual/development disabilities, as identified per MDHHS staff qualification criteria.

Notice of Resolution: Written statement of the PIHP of the resolution of an Appeal or Grievance, which must be provided to the Enrollees described in 42CFR 438.408

Organizational Provider: Entities under contract with the PIHP that directly employ and/or contract with individuals to provide specialty services and supports. Examples of organizational providers include, but are not limited to CMHSPs, hospitals, psychiatric hospitals, partial hospitalization programs, substance use disorder providers, case management programs, assertive community treatment programs, and skill building programs.

PIHP: An acronym for Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic area under contract with the State. There are 10 PIHPs in Michigan, and each one is organized as a Regional Entity or a CMHSP, according to the Mental Health Code.

Recipient Rights Complaint: Written or verbal statement by the Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through processes established in Chapter 7a.

Service Authorization: The PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under the applicable law, including but not limited to 42 CFR

438.210.

State Fair Hearing: Impartial state level review for 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 for in detail Subpart E of 42 CFR Part 431.

IV. STANDARDS:

A. GENERAL

The Grievance and Appeal System must provide Enrollees:

a. An Appeal process (one level only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
b. A Grievance process.
c. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints.
d. 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.
e. Information that if the PIHP fails to adhere to notice and timing requirements as outlined in the PIHP Appeal process, the Enrollee is deemed to have exhausted the PIHPs Appeal process. The Enrollee may initiate a State Fair Hearing.
f. The right to request and have Medicaid covered benefits continued while the PIHP Appeal and/or the State Fair Hearing is pending.
g. 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.

B. NOTICE OF ADVERSE BENEFIT DETERMINATION

The PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination.

i. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements:
   a. The 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" and meets the needs of those with limited English proficiency and/or limited reading proficiency).

b. Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
c. Description of Adverse Benefit Determination has made or intends to make.
d. The reason(s) for the Adverse Benefit Determination and policy/authority relied upon in making the determination.
e. 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).
f. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHPs Appeal process, and the right to request a State Fair Hearing thereafter.
g. Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal.
h. 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").
i. Description of the procedures that the Enrollee is required to follow to exercise any of these rights.
j. An explanation that the Enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.

ii. <u>Timing of Notice:</u>
   a. <u>Adequate Notice of Adverse Benefit Determination:</u>
      i. 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.
      ii. For a Service Authorization decision that denies or limits services, notice must be provided to the Enrollee within **14 calendar 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.
      iii. For Service Authorization Decisions not reached within **14 calendar 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.

NOTE: 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 the extension is in the Enrollee's best interest. If the PIHP extends the time **NOT** 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/she disagrees with that decision; and (iii.) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

b. Advance Notice of Adverse Benefit Determination:
    i. Required for reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services.
    ii. Must be provided to the Enrollee at least **10 calendar days** prior to the proposed effective date.
    iii. Limited Exceptions: The PIHP may mail an adequate notice of action not later than the date of the action to terminate, suspend, or reduce previously authorized services, **IF**:
        1. The PIHP has verified information confirming the death of the Enrollee.
        2. The PIHP receives a clear and written statement signed by the Enrollee that he/she no longer wishes services, or that gives information that requires termination or reduction of services, and indicates the Enrollee understands this must be the result of supplying that information.
        3. The Enrollee has been admitted to an institution where he/she is ineligible under the plan for further services.
        4. The Enrollee's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address.
        5. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
        6. A change in the level of medical care is prescribed by the Enrollee's physician.
        7. A change in the level of medical care is prescribed by the Enrollee's physician.
        8. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the SSA.
        9. The date of action will occur in less than **10 calendar days.**
        10. 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 calendar days** before the date of action).

c. Required Recipients of Notice of Adverse Benefit Determination:
    i. The Enrollee must be provided written notice.
    ii. 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.

C. 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 the following occur:
    a. The Enrollee files the request for Appeal timely (within **60 calendar days** from the date on the Adverse Benefit Determination Notice).
    b. 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).
    c. The period covered by the original authorization has not expired.
b. Duration of Continued or Reinstated Benefits. 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 the following occurs:
    a. The Enrollee withdraws the Appeal or request for State Fair Hearing;
    b. The Enrollee fails to request a State Fair Hearing and continuation of benefits within **10 calendar days** after the PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;
    c. 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 PIHPs Adverse Benefit Determination, the PIHP may, consistent with the State's usual policy on recoveries and as specified in the PIHPs 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.
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 State 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.
f. If the PIHP or the State 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.

D. PIHP APPEAL PROCESS

a. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq. provides the Enrollee the right to Appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of Appeal. The Enrollee

may request an internal review by the PIHP, which is the first of two Appeal levels, under the following conditions:

a. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal.
b. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests an expedited resolution, an oral request for Appeal mut be followed by a written, signed request for Appeal.

NOTE: Oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

c. 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. <u>PIHP Responsibilities when the Enrollee Requests an Appeal:</u>

a. Provide the Enrollee reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
b. Acknowledge receipt of each Appeal.
c. Maintain a record of Appeals for review by the State as part of its quality strategy.
d. Ensure that the individual(s) who make the decisions on Appeals:
    1. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;
    2. 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; and
    3. Consider all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
e. 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;
f. 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.

g. Provide opportunity to include as parties to the Appeal the Enrollee and his/her representative or the legal representative of a deceased Enrollee's estate;
h. 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:
   a. 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.
   b. Expedited Appeal Resolution (timing):
      1. 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.
      2. The PIHP may not take punitive action against provider who requests an expedited resolution or supports the Enrollee's Appeal.
      3. If a request for expedited resolution is denied, the PIHP must:
         a. Transfer the Appeal to the timeframe for standard resolution.
         b. Make reasonable efforts to give the Enrollee prompt oral notice of the denial.
         c. 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.
         d. Resolve the Appeal as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days.**
      4. 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.
   c. 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.
      1. If the PIHP extends resolution/notice timeframes, it must complete **all** the following:
         a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
         b. 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;

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

d. Appeal Resolution Notice Format:

1. 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.
2. The PIHP must utilize the required notice templates for Appeals and Grievances provided MDHHS. These templates incorporate the information needed to meet the record keeping requirements. At a minimum must contain the following information:
    a. A general description of the reason for the Appeal or Grievance
    b. The date received
    c. The date of each review or, if applicable, review meeting.
    d. Resolution at each level of the Appeal or Grievance if applicable.
    e. Date of resolution at each level, if applicable.
    f. Name of the covered Enrollee for whom the Appeal or Grievance was filed.

This recordkeeping must be maintained in a manner accessible to the State and Center for Medicare and Medicaid Services (CMS).

3. 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," and meets the needs of those with limited English proficiency and/or limited reading proficiency).

e. Appeal Resolution Notice Content:

1. The notice of resolution must include the results of the resolution and the date it was completed.
2. When the Appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
    a. Right to request a State Fair Hearing, and how to do so;
    b. Right to request to receive benefits while the State Fair Hearing is pending, and how to make the request; and
    c. Potential liability for the cost of those benefits if the hearing decision upholds the PIHPs Adverse Benefit Determination.

E. GRIEVANCE PROCESS

a. Federal regulations provide the Enrollee the right to a Grievance process to seek resolution to issues that are not Adverse Benefit Determinations.
b. Generally:

a. The Enrollee must file a Grievance with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.
b. A Grievance may be filed either orally or in writing at any time by the Enrollee, guardian, or parent of a minor child, or his/her legal representative.
c. The 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 Michigan Administrative Hearing System (MAHS) using the State Fair Hearing process.

c. PIHP Responsibility when the Enrollee Files a Grievance:
   a. Provide the Enrollee reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
   b. Acknowledge receipt of the Grievance.
   c. Maintain a record of Grievances for review by the State as part of its quality strategy.
   d. Submit the written Grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination.
   e. Ensure that the individual(s) who make the decisions on the Grievance:
      1. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual.
      2. 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.
      3. Consider all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
   f. Coordinates as appropriate with Fair Hearing Officers and local Office of Recipient Rights.

d. Grievance Resolution Timing and Notice Requirements
   a. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the delay the PIHP received the Grievance.
   b. Extensions 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.

1. If the PIHP extends resolution/notice timeframes, it must complete **all** the following:
    a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
    b. 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
    c. Resolve the Grievance as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

c. Format and Content of Notice of Grievance Resolution:

1. The 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," and meets the needs of those with limited English proficiency and/or limited reading proficiency).
2. The notice of Grievance resolution must include:
    a. The results of the Grievance process;
    b. The date the Grievance process was concluded;
    c. The Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90 calendar days** from the date of the Grievance; and
    d. Instructions on how to access the State Fair Hearing process, if applicable.

F. STATE FAIR HEARING APPEAL PROCESS

a. Federal regulations provide the 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;
    a. After receiving notice, the PIHP is, after Appeal, upholding an Adverse Benefit Determination.
    b. When the PIHP fails to adhere to the notice and timing requirements for resolution of Appeals and Grievances as described in 42 CFR 438.408.
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 the Enrollee, independent of the State and PIHP, and not extend any timeframes or disrupt continuation of benefits).
c. The PIHP may not limit or interfere with the Enrollee's freedom to make a request for a State Fair Hearing.

d. The Enrollee is given **120 calendar days** from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing.
e. The PIHP is required to continue benefits if the conditions described in section 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 Enrollee and his/her representative, or the representative of a deceases Enrollee's estate, and the PIHP. A Recipient Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
h. Expedited hearings are available.

G. 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 PIHPs record of each Appeal and/or Grievance must contain, at a minimum:

i. A general description of the reason for the Appeal or Grievance;
ii. The date received;
iii. The date of each review, or if applicable, the review meeting;
iv. The resolution at each level of the Appeal or Grievance, if applicable;
v. The date of the resolution at each level, if applicable;
vi. Name of the covered Enrollee for whom the Appeal or Grievance was filed.

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

H. RECIPIENT RIGHTS COMPLAINT PROCESS

The Enrollee, as a recipient of Mental Health Services, has rights to file Recipient Rights complaints under the authority of the State Mental Health Code. Recipient Rights compliant requirements are articulated in the CMHSP Managed Mental Health Supports and Services contract, CMHSP Local Dispute Resolution Process.

V. PROCEDURES:

A. GENERAL

i. Staff will assist Enrollee with filing grievances, appeals, state fair hearings, or

contacting the appropriate office of jurisdictions.

ii. Staff shall determine if the complaint is a Grievance, Appeal, or Recipient Rights issue and refer appropriately.

iii. An Enrollee shall file a grievance to the local CMHSP for mental health related complaints, or the PIHP office for SUD service-related complaints.
   a. The CMHSP staff will log all grievances and information into the respective EMR.

iv. Enrollees are to be directed to the PIHP Grievance and Appeal Office for filing appeals. This is not a delegated function to CMHSP or SUD providers.
   a. Designated staff will log all relevant information into the appropriate EMR.

VI. EXHIBITS:

None.

VII. REFERENCES:

42 CFR 438
42 CFR 431, Subpart E
MDHHS Appeal and Grievance Resolution Process Technical Requirement
MDHHS/PIHP Contract: Customer Service Standards
PIHP Glossary Project