MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Medicaid Enrollee Appeals/Grievances		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 5	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 07.01.2014 **Review Date: 07.05.2022** **Revision Eff. Date:**	**Related Policies:** Consumer Services Policy

Purpose

To establish a process to resolve complaints and ensure recipient notification of a person's right to file appeals and grievances, including internal appeals, grievances and administrative hearings related to dissatisfaction with services authorized and/or delivered by Mid-State Health Network's (MSHN) Provider Network.

Policy

MSHN delegates the responsibility for the appeals/grievance processes consistent with federal and state guidelines to the Community Mental Health Service Program (CMHSP) Participants and Substance Use Disorder (SUD) providers, with oversight and monitoring by MSHN, including:

1. Local Appeal process for recipients, guardians, or subcontracted providers to challenge an Adverse Benefit Determination by the CMHSP Participants/SUD Provider Network or its agents regarding a consumer's services;

2. The right to concurrently file a local Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints;

3. Access to the State Fair Hearing process after a local Appeal denial of an Adverse Benefit Determination is received;

4. The right to request and have Medicaid covered benefits continued during the local Appeal and/or the State Fair Hearing if the request for continuation of benefits is timely (on or before the latter of 10 calendar days from the date of the notice of Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination); customers may be asked to pay for a portion of the services received during the appeal and/or Fair Hearing process if the outcome upholds the decision being appealed;

5. A local grievance process for any recipient of the PIHP to express dissatisfaction about any matter other than those that meet the definition of an "Adverse Benefit Determination" or those that meet the definition of a Recipient Rights issue;

6. Complaints should be resolved at the level closest to service delivery when possible but information regarding access to all complaint resolution processes will be provided to the Medicaid Enrollee;

7. 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 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 against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so;

8. All processes will promote the resolution of concerns and improvement of the quality of care;

9. Each CMHSP Participant/ SUD Provider shall have a local procedure in place that is in compliance with the Michigan Department of Health and Human Services (MDHHS), Grievance and Appeal Technical Requirement and 42 CFR 438 Subpart F – Grievance and Appeal System.

Applies to:

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

Definitions:

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

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
b. Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
c. Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
d. Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).
e. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
g. Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
h. Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*

i. Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

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

k. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

Adequate Notice of Adverse Benefit Determination**:** Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

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

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

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

CMHSP: Community Mental Health Service Program

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program**.** *42 CFR 438.2*.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

Grievance: 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.

MSHN: Mid-State Health Network

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.
PIHP: Prepaid Inpatient Health Plan.
Recipient Rights Complaint: Written or verbal statement by 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.
SUD Provider Network: Refers to a SUD Provider that is directly under contract with PIHP MSHN to provide services and/or supports

Other Related Procedures:

N/A

References/Legal Authority:

The following federal and state statutes establish the standards for MSHN's Appeals and Grievance procedures for Medicaid Recipients:
1. 42 CFR 438.10: Information Requirements
2. 42 CFR 431.200 Fair Hearings
3. 42 CFR 438.400 Appeals and Grievances
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements, L. Grievance and Appeals Process
for Beneficiaries
5. State of Michigan/PIHP Contract attachment: Appeals and Grievances Technical Requirements (P.6.3.1.1)
6. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)
7. Michigan Mental Health Code (MHC) MCL 330.1705 (Medical Second Opinion)

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Formatting Update	Customer Service and Rights Specialist
11.21.2016	Annual Review, language edition	Customer Service Committee
10.16.2017	Annual Review, revised definitions	Customer Service Committee

12.3.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee