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REGION 10 PIHP

SUBJECT	CHAPTER	SECTION	SUBJECT
Grievance and Appeal System	07	02	01

CHAPTER	SECTION
Rights of Person Served	Grievance 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 of 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 processes prior to the filing of a recipient rights complaint 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 the 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.
- 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 Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization.
- Failure to provide services 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 the standard appeal request is received by the PIHP.
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date the standard appeal request is received by the PIHP
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date the expedited appeal request is received by the PIHP.
- For a resident of a rural area with one Managed Care Organization (MCO), the denial of the enrollee's request to exercise the enrollee's right, under 438.52 (b)(2)(ii), and to obtain services outside the network.
- Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility.

Adequate Adverse Benefit Determination Notice: Written statement advising the enrollee of a decision to deny or limit authorization of Medicaid services requested and the reasons why. The PIHP must mail the notice within timeframes identified in the Code of Federal Regulations (CFR) and written in an easily understood manner. (42 CFR 438.404; 42 CFR 438.10)

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. (42 CFR 438.404(c)(1); 42 CFR 431.211)

Appeal: A review at the local level by a PIHP of and Adverse Benefit Determination (42 CFR 438.400(b))

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

Community Mental Health Services Program (CMHSP): A CMHSP is a program that contracts with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of an individual's ability to pay. (Michigan Mental Health Code 330.1100a, 330.1206)

Enrollee: A Medicaid beneficiary who is currently enrolled in a PIHP, Entity managed care program. (42 CFR 438.2)

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by the 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); 42 CFR 438.210)

Grievance: The enrollee's expression of dissatisfaction with the PIHP and/or the CMHSP about any matter other than an adverse benefit determination grievance may include, but are not limited to, any aspect of the operations, activities, or behavior of PIHP or its Provider Network, regardless of whether remedial action is requested. Specific examples include the quality of care or services provided, problems getting an appointment or having to wait a long time for an appointment, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right to dispute an extension of time proposed by the PIHP to make a service authorization decision. (42 CFR 438.400(b))

Grievance Process: Impartial local level 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 present the PIHP at a State Fair Hearing.

Medicaid Services: Services provided to the enrollee under the authority of the Medicaid State Plan, 1115 Behavioral Health Demonstration Waiver, Healthy Michigan Plan, MIChild, 1915(i) Waiver, 1915(c) Waivers, and/or Section 1915(b)(3) of the Social Security Act (SSA).

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

Prepaid Inpatient Health Plan (PIHP): A PIHP is an organization as defined in 42 CFR Part 438 and meets the requirements of MCL 330.1204b.

Provider: An individual or entity engaged in the delivery, ordering, or referring of services

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 the 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 applicable law, including but not limited to *42 CFR 438.210*.

State Fair Hearing: Impartial state-level review of the Medicaid Enrollee's appeal of an Adverse Benefit Determination presided over by MDHHS Administrative Law Judge. Also referred to as an "Administrative Hearing". The State Fair Hearing Process is set for in detail in Subpart E of 42 CFR Part 431.

Substantiated: The decision that there is sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

Unsubstantiated: The decision that there is not sufficient evidence to support the enrollee's expression of dissatisfaction and merit for the grievance.

IV. STANDARDS:

A. The PIHP and Network will ensure that enrollees are offered Due Process whenever their Medicaid benefits are denied, reduced, or terminated. The PIHP Grievance and Appeal System provides a process to help protect the Medicaid enrollee Due Process rights.

B. Staff will assist enrollee with filing grievances, appeals, state fair hearings, or contacting the appropriate office of jurisdiction.

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

D. Enrollees are to be directed to the PIHP customer service department for filing appeals. This is not a delegated function to CMHSP or SUD providers.
    1. Designated staff will log all relevant information into the appropriate EMR.

V. PROCEDURES:

A. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS
    1. 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.

h) Appeal and Grievance notice templates are attached to the MDHHS Appeal and Grievance Resolution Process Technical Requirement policy. These templates are required for all appeal and grievance notices.

B. RECORD KEEPING REQUIREMENTS

1. 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. (42 CFR 438.416(a)).
2. PIHPs record of each Appeal and/or Grievance must contain, at a minimum (42 CFR 438.16(b)):
    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, 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 enrollee for whom the Appeal or Grievance was filed.
3. PIHPs must maintain such records. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. (42 CFR 438.16(c))
   All Appeal and Grievance records must be retained for a period of ten (10) years from the final date the case was resolved.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION

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

1. 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 being made or intends to make.
d) The reason(s) for the adverse benefit determination, including 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. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 CFR 438.404(b)(2)). Notification of the enrollee's right to request an appeal of the PIHPs adverse benefit determination, including information on exhausting the PIHPs one level of appeal, and the right to request a State Fair Hearing thereafter. (42 CFR 438.404(b)(3))
e) Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal. 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"). (42 CFR 438.404(b)(6))
f) Description of the procedures that the Enrollee is required to follow to exercise any of these rights. (42 CFR 438.404(b)(4))
g) An explanation that the Enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.

2. <u>Timing of Notice (42 CFR 438.404(c)):</u>
   a) <u>Adequate Notice of Adverse Benefit Determination:</u>
      i. For a denial of payment for services requested but 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)).
      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 (42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3) and (6)) .
      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. (42 CFR 438.404(c)(4); 42 CFR 438.408(c)(2); 438.410(c)(2)).

b) Advance Notice of Adverse Benefit Determination:

i. Required for reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services. Must be provided to the enrollee at least 10 calendar days prior to the proposed effective date. (42 CFR 438.404(c)(1); 42 CFR 431.211)

ii. Exceptions from advance notice:

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:

a. The PIHP has verified information confirming the death of the Enrollee.
b. The PIHP receives a clear and written statement signed by the Enrollee that he/she no longer wishes services per 42 CFR 431.213(b)(1); 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 (42 CFR 431.213(b)(2)).
c. The Enrollee has been admitted to an institution where he/she is ineligible under the plan for further services (42 CFR 431.213(c)).
d. The Enrollee's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address42 CFR 431.213(d)).
e. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth (42 CFR 431.213(e)).
f. A change in the level of medical care is prescribed by the Enrollee's physician (42 CFR 431.213(f)).

g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the SSA (42 CFR 431.213(g)).
h. The date of action will occur in less than **10 calendar days** (431.213(h).
i. 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). (42 CFR 431.215).

c) Required Recipients of Notice of Adverse Benefit Determination:
   i. The Enrollee must be provided written notice. (42 CFR 438.404(a); 42 CFR 438.210(c)).
   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. (42 CFR 438.210(c))
   iii. 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 PCP process still constitutes an adverse benefit determination and requires a written notice of action. (42 CRF 438.210 9e).

D. MEDICAID BENEFITS SERVICES CONTINUATION OR REINSTATEMENT

1. Continuation of benefits:

   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 (42 CFR 438.420(b)(1); 42 CFR 438.402(c)(ii)).
   b) The enrollee files for continuation of benefits timely (on or before the latter of within ten (10) calendar days of the PIHP sending the notice of Adverse Benefit Determination; or the intended effective date of the proposed Adverse Benefit Determination. (42 CFR 438.420(b)(5); 42 CFR 438.420(a) "Timely files").
   c) The Appeal involves the termination, suspension, or reduction of previously authorized services (42 CFR 438.420(b)(2)).
   d) The services were ordered by an authorized provider (42 CFR 438.420(b)(3));

e) The period covered by the original authorization has not expired (42 CFR 438.420(b)(4)); and

2. Duration of Continued or Reinstated Benefits42 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 the following occurs:
   a) The Enrollee withdraws the Appeal or request for State Fair Hearing (42 CFR 438.420(c)(1));
   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 under 42 CFR 438. 408(d)(2). (42 CFR 438.420(c)(2));
   c) A State Fair Hearing office issues a decision adverse to the Enrollee (42 CFR 438.420(c)(3)).
3. Enrollee responsibility for services furnished while the appeal or state fair hearing is pending:
   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 under 42 CFR 431.230(b) 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 (42 CFR 438.420(d)).
4. Reinstating services:
   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 (42 CFR 431.231(c)).
5. Services furnished while the appeal is pending:
   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 (42 CFR 438.424(b)).
6. Services not furnished while the appeal is pending:
   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 (42 CFR 438.424(a)).

E. PIHP APPEAL PROCESS

1. 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 (42 CFR 438.402(c)(2)(ii)) .
    b) The Enrollee may request an Appeal either orally or in writing (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)).
    c) In the circumstances described above under the Section entitled "Continuation of Benefits, "the PIHP will be required to continue/reinstate Medicaid Services while the appeal or state fair hearing is pending, until one of the events described in that section occurs. (42 CFR 438.420(c)).
2. <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 (42 CFR 438.406(a)).
    b) Acknowledge receipt of an expedited Appeal within 72 hours of receipt. The PIHP must acknowledge receipt of each standard Appeal within five (5) business days. (42 CFR 438.406(b)(1); 42 CFR 438.408(b)(3))
    c) Maintain a record of Appeals for review by the State as part of its quality strategy (42 CFR 438.416(a)) .
    d) Ensure that the individual(s) who make the decisions on Appeals are individuals:
        i. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual (42 CFR 438.406(b)(2)(i));
        ii. Who when deciding an Appeal that involves either involves clinical issues, or 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 (42 CFR 438.406(b)(2)(ii)); and
        iii. 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 (42 CFR 438.406(b)(2)(iii)) .

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 (42 CFR 438.406(b)(4)) .

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 (42 CFR 438.406(b)(5)).

g) Provide opportunity to include as parties to the Appeal the Enrollee the enrollee's 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. The enrollee can request a State Fair Hearing only after receiving notice that the PIHP is upholding the Adverse Benefit Determination (42 CFR 438.408(f)(1)). In the case of a PIHP that fails to adhere to the notice and timing requirements of 30 days, the enrollee is deemed to have exhausted the PIHP's appeals process. The enrollee may initiate a State fair hearing (42 CFR 438.408(c)(3)).

3. <u>Appeal Resolution Timing and Notice Requirements:</u>

a) <u>Standard Appeal Resolution (timing):</u>
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 (42 CFR 438.408(b)(2).

b) <u>Expedited Appeal Resolution (timing):</u>

i. Each PIHP must establish and maintain an expedited review process for appeals when 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))

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

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

a. Transfer the Appeal to the timeframe for standard resolution (42 CFR 438.410(c)(1)) .

b. Make reasonable efforts to give the Enrollee prompt oral notice of the denial if the PIHP extends the timeframes not at the request of the enrollee (42 CFR 438.408, 438.410(c)(2)).
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 (42 CFR 438.408(c)(2); 438.410(c)(2)) .
d. Resolve the Appeal as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** (42 CFR 438.408(c)(2)(iii)) .

iv. 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(b)(3)).

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 (42 CFR 438.408(c)(1)).

i. If the PIHP extends resolution/notice timeframes not at the request of the enrollee , it must complete **all** the following(42 CFR 438.408(c)(2))
a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay (42 CFR 438.408(c)(2)(i)) ;
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 (42 CFR 438.408(c)(2)(ii)).
c. Resolve the Appeal as expeditiously as the Enrollee's health condition requires, and not later than the date the extension expires (42 CFR 438.408(c)(2)(iii)).

d) Appeal Resolution Notice Format:
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)) .

i. The enrollee notices must meet the requirements of 42 CFR 438.10(c)(1) that states "each PIHP entity must provide all required information 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:
   i. The notice of resolution must include the results of the resolution and the date it was completed (42 CFR 438.408(e)(1)).
   ii. 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 (42 CFR 438.408(e)(2)(i));
      b. Right to request to receive benefits while the State Fair Hearing is pending, and how to make the request (42 CFR 438.408(e)(2)(ii)); and
      c. That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's adverse benefit determination. (42 CFR 438.408(e)(2)(iii))

F. GRIEVANCE PROCESS

Federal regulations provide the enrollee the means of 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 of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the PIHP to make an authorization decision. (42 CFR 438.400(b) "Grievance")

1. 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 at any time by the enrollee, guardian, or parent of a minor child, or the enrollee's authorized representative. (42 CFR 438.402(c)(1)(ii); 42 CFR 438.402(c)(2)(i))
2. 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 (42 CFR 438.406(a)) .
   b) Acknowledge receipt of the Grievance within five (5) business days. (42 CFR 438.406(b)(1))
   c) Maintain a record of Grievances for review by the State as part of its quality strategy (42 CFR 438.416(a)).
   d) Ensure that the individual(s) who make the decisions on the Grievance are individuals:
      i. Who 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)) .

ii. Who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues. (42 CFR 438.406(b)(2)(ii))

iii. Who 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 previously. (42 CFR 438.406(b)(2)(iii))

e) Coordinates as appropriate with Hearing Officer and local Office of Recipient Rights.

3. 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 day the PIHP received the Grievance (42 CFR 438.408(b)(1)).

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 (42 CFR 438.408(c)) .

i. 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 (42 CFR 438.408(c)(2)(i)) ;

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 (42 CFR 438.408(c)(2)(ii)) ; and

c) Format and Content of Notice of Grievance Resolution:

i. The enrollee notices must meet the requirements of 42 CFR 438.10(c)(1) that states "each PIHP entity must provide all required information 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.

ii. The notice of Grievance resolution must include:

a. The results of the Grievance process.

b. The date the Grievance process was concluded.

G. STATE FAIR HEARING APPEAL PROCESS

1. 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 that the PIHP is upholding an Adverse Benefit Determination after Appeal (42 CFR 438.408(f)(1));
    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(f)(1)(i).
2. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions are met:
    a) <u>The review must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing. (42 CFR 438.408(f)(1)(ii)(A))</u>
    b) <u>The review must be independent of both the State and the PIHP. (42 CFR 438.408(f)(1)(ii)(B))</u>
    c) <u>The review must be offered without any cost to the enrollee. (42 CFR 438.408(f)(1)(ii)(C))</u>
    d) <u>The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits. (42 CFR 438.408(f)(1)(ii)(D))</u>
3. The PIHP may not limit or interfere with the Enrollee's freedom to make a request for a State Fair Hearing.
4. The enrollee is given no more than 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))
5. The PIHP is required to continue benefits if the conditions described in section VII - Medicaid Services Continuation or Reinstatement are satisfied and for the durations described therein.
6. 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 (42 CFR 431.231(c)).
7. The parties to the State Fair Hearing include the Enrollee and the enrollee's representative, or the representative of a deceased 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.
8. Expedited hearings are available.

VI. **<u>EXHIBITS:</u>**

None.

VII. **REFERENCES:**

A. 42 CFR 438
B. 42 CFR 431, Subpart E
C. MDHHS Appeal and Grievance Resolution Process Technical Requirement
D. MDHHS/PIHP Contract