Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Consumer Appeals Policy***
Committee/Department: Regional UM Committee	**Local Policy Number (if used)**
Implementation Date 09/08/2023	**Regional Approval Date** 08/25/2023

Reviewed by:	**Recommendation Date:**
ROC	06/14/2023
CMH Board:	**Approval Date:**
Lenawee	07/27/2023
Livingston	07/25/2023
Monroe	07/27/2023
Washtenaw	08/25/2023

I. PURPOSE

To establish policy and procedures to receive and resolve appeals regarding the denial, suspension, reduction, or termination of services; the timeliness of service provision; family support subsidy appeals; second opinion requests; local level appeals, and state level appeals.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
06/05/2015	Revised to reflect the External Quality Review recommendations.
02/24/2017	Revised to reflect Section 942 of P A 268 of 2016 Revised Memo 12 15 16
10/01/2017	Revised to reflect the revised Managed Care Rules.
01/28/2019	Revised to reflect corrections from EQR review
12/17/2021	Revised to reflect new ABD language that provides grievance rights only.
06/24/2022	Revised to clarify local appeal roles; add state mediation option, notification requirements for extension of service authorization decisions, clarification of 2nd opinion, SUD provider roles; updated reporting requirements
08/25/2023	Revised to reflect the External Quality Review required actions and recommendations.

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

All grievance processes will be initiated at the local Board level and will be handled by the local Customer Services department of each local Board. All policy and procedures for grievance processes can be found in the CMHPSM Customer Services Policy.

All appeal processes will be initiated at the local Board level and will be handled locally. Each CMHSP/ROSC Core Provider/SUD Provider shall have a designee to handle internal/local appeals until:

a. A Medicaid consumer/individual served requests a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) after receiving notice that an adverse benefit determination (ABD) was upheld by the Local Dispute Resolution Committee (LDRC).
b. A Medicaid consumer/individual served initiates a State Fair Hearing with MOAHR because the PIHP/CMHSP/SUD Provider failed to adhere to the notice and timing requirements. (When this occurs, a consumer/individual served is deemed to have exhausted the internal appeals processes).
c. A Non-Medicaid consumer/individual served completes the local appeal/Local Dispute Resolution Process and requests a Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution Hearing.

Upon the request of a state level hearing/appeal, the designated Fair Hearings Officer will assume responsibility for the process in collaboration with the local Board. This includes working in conjunction with MOAHR on behalf of the local Board, representing the local Board for the State Fair Hearing requests and representing the local Board for MDHHS Alternative Dispute Resolution requests.

All appeal processes will be handled in accordance with the procedures attached to this policy. All appeal processes shall be:

1. Timely
2. Fair to all parties
3. Administratively simple
4. Objective and credible
5. Accessible and understandable to consumers/individuals served and providers
6. Cost and resource efficient
7. Subject to quality improvement review

These processes shall:

i. Not interfere with communication between consumers/individuals served and their service providers.
ii. Assure that service providers who participate in an appeal process on behalf of a consumer/individual served are free from discrimination or retaliation.
iii. Assure that a consumer/individual served/legal representative who files an appeal is free from discrimination or retaliation.

V. DEFINITIONS

Access Staff – Staff designated to provide intake and/or assessment of an applicant's/consumer/individual's eligibility and/or medical necessity for requested services. Staff provide screenings and referrals using diagnostic criteria for mental health and substance abuse services. Staff also assess the needs of callers, make appropriate referrals, and provide authorization of mental health and substance use disorder services based on consumer/individual served need, eligibility, and available funding resources.

Action (also referred to as adverse action) – A benefit/service determination related to Non-Medicaid/General Funds by which the CMHSP determines any of the following covered by Non-Medicaid/General Funds:

- Denial of inpatient psychiatric hospitalization or denial of a requested alternate service if inpatient is denied.
- Denial of services where there are rights to a second opinion.
- Suspension, reduction, or termination of reduction of existing supports/services.

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

Adequate Notice - Written notice to an applicant/consumer/individual served/ legal representative that a service is being approved or an adverse benefit determination (ABD) has occurred that is not a suspension, reduction or termination.

Administrative Law Judge (ALJ) - A person designated by the state to serve as a judge for the Michigan Administrative Hearing System to conduct Medicaid State Fair Hearings.

Advance Notice - Written notice of an ABD or action to a consumer/individual served/legal representative that a service is being suspended, reduced, or terminated. For Medicaid consumers/individuals, this notice must be mailed at least 10 days before the effective date of the service change. For Non-Medicaid consumers/individuals, this notice must be mailed at least 30 days before the effective date of the service change.

Adverse Benefit Determination (ABD) – A benefit/service determination specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following for Medicaid services:

1. The 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.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or part, of a payment for service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.
4. The failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning process and as authorized by the PIHP/CMHSP.
5. The failure of a PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request.
6. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer/individual’s request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.
7. The denial of a consumer/individual’s request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other consumer/individual served financial liabilities.
8. The failure of the PIHP/CMHSP to act within the required timeframes regarding standard resolution of appeals.

Alternative Dispute Resolution Process - A program of the Michigan Department of Health & Human Services with responsibility for conducting an appeal which was not resolved at the local level through the LDRP. This process may occur after the LDRP review has

been exhausted and Community Mental Health (CMH) upholds the adverse action at the local appeal.

Applicant - A consumer/individual served, or his/her legal representative, who makes an initial request for mental health or substance use disorder services, including services provided by agencies under contract to the PIHP.

Authorized Hearing Representative (AHR) - Any person designated in writing by a consumer/individual served (or the consumer/individual's legal representative) to stand in for or represent the consumer/individual served during a local/internal or state level appeal, or a representative/parent of a minor, or the consumer/individual's spouse, widow, or widower, if there is no one else with authority to represent the consumer/individual served.

Community Mental Health Partnership of Southeast Michigan (CMHPSM) - The Regional Entity that serves as the Pre-Paid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) - A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consumer/individual served - A consumer/individual served who is receiving mental health or substance use disorder services, including services provided by entities under contract with the PIHP.

Core Provider - A local provider of substance use disorder services utilizing the ROSC model that provides for and/or coordinates all levels of care for consumers/individuals with substance use disorders.

Denial - An action taken by the CMHSP with Non-Medicaid/General Funds services, by which a service is denied in whole, denied in part, or currently authorized services or supports are to be suspended, terminated, or reduced. This is also known as an Action or Adverse Action.

Delay – An action specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following and for which Medicaid consumers/individuals have a right to file a grievance:

1. A delay in making a standard/routine service authorization decision of a service request within 14 calendar days from the date of receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
2. A delay in making a decision regarding a request for an expedited service authorization decision within 72 hours from the receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
3. A delay in resolving standard internal appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. The resolution timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.

4. A denial of a request for an expedited appeal. The request for an expedited appeal within 72 hours can be denied and extended (hence delayed) to the standard 30-day appeal time frame if the consumer/individual served is notified of the right to file a grievance.
5. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.

Expedited Appeal – The prompt review of an ABD or action, requested by a consumer/individual served/legal representative or a provider on behalf of the consumer/individual served, when the time necessary for the normal/standard review process could seriously jeopardize the consumer/individual's life or health or ability to attain, maintain or regain maximum function. If the consumer/individual served/legal representative requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the consumer/individual's provider makes the request or supports the consumer/individual's request, the PIHP/CMHSP must grant the request.

Fair Hearings Officer (FHO) – Person assigned by the CMHSP Board for mental health appeals, or by PIHP for Substance Use Disorder (SUD) appeals, to handle state level appeals, maintain appeals-related data, and report this data to the PIHP.

Grievance – An expression of dissatisfaction about any matter related to PIHP/CMHSP service issues, other than an adverse benefit determination or action, which does not involve a Recipient Rights complaint. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer/individual served. Grievances not completed according to time frames are also considered a Medicaid ABD and are appealable.

Grievance Process - Impartial local level review of a consumer/individual's grievance.

Grievance and Appeal System – Processes the PIHP implements to handle appeals, grievances and the collecting and tracking of appeal and grievance information.

Internal Appeal – A request for the PIHP/CMHSP to review a Medicaid ABD at the local level.

Legal Representative – The representative, parent of a minor, or other person authorized by law to represent an applicant/consumer/individual served.

Local Appeal – A request for the PIHP/CMHSP to review a denial, suspension, termination or reduction of Non-Medicaid/General Funds services and/or supports at the local level.

Local Dispute Resolution Process (LDRP) - A review of a Non-Medicaid/General Funds local appeal convened by the local entity (either the CMHSP or the ROSC Core Provider). The LDRP for mental health services is chaired by the designee of the CMHSP Director; the LDRP for substance use disorder services is chaired by the SUD Director. The LDRP has the responsibility for reviewing local appeals regarding mental health or substance use disorder services covered with Non-Medicaid/General Funds by the PIHP/Core Provider and those of its contract agencies.

Medicaid Services – Services provided to a consumer/individual served under the authority of the Medicaid State Plan, EPSDT coverage, 1915(i) waiver, the 1115 demonstration waivers, and/or the 1915(c) program waivers (Habilitation Supports, SED or Children's Waivers.

Mediation - An informal dispute resolution process in which an impartial, neutral individual who has no authoritative decision-making power assists parties to reach their own settlement of issues in a confidential setting.

Michigan Office of Administrative Hearings and Rules (MOAHR) - The entity charged by the state with responsibility for conducting Medicaid State Fair Hearings.

Notice of Resolution – Written statement of the PIHP/CMHSP resolution of a grievance or appeal, which must be provided to the consumer/individual served as described in *42 CFR 438.408*.

Recipient Rights Complaint – A written or verbal statement by a consumer/individual served or anyone acting on behalf of a consumer/individual served alleging a violation of a consumer/individual's legally protected rights, including rights cited in the Michigan Mental Health Code, Chapter 7, which is resolved through the processes established in Chapter 7A.

Regional Entity - The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, intellectual/developmental disabilities, and substance use disorder needs.

Service Authorization – PIHP/CMHSP 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 – (Also called a Medicaid Fair Hearing). An Administrative Law Judge (ALJ) from MOAHR completes an impartial state level review of a decision made by the PIHP or the local CMHSP, or one of its contract agencies, regarding Medicaid services.

Utilization Review (UR) - Process in which established criteria are used to recommend or evaluate services provided in terms of cost effectiveness, medical necessity, and efficient use of resources.

VI. STANDARDS

A. General Standards

1. Both grievance and appeals systems shall have processes in place for consumers/individuals served, promote the resolution of concerns, and support and enhance the goal of improving the quality of services.
2. Consumers/individuals served/legal representatives shall be informed of their right to access grievance and appeal processes if they are dissatisfied or concerned at any point during the delivery of mental health services or supports.
3. Customer Services and the Office of Recipient Rights (ORR) shall assist applicants/consumers/individuals served/legal representatives of their legal rights to

access all grievance and/or appeal processes which they are eligible.

4. Providers shall be informed of their right to access the provider appeal process when they are denied or limited authorization for services, or when they wish to file an expedited appeal on behalf of a consumer/individual served.
5. Providers, acting on behalf of a consumer/individual served/applicant and with the consumer/individual's/legal representative's written consent, may file an appeal as the consumer/individual's Authorized Hearing Representative (AHR).
6. If an external/contractual provider makes a service request on behalf of a consumer/individual served, and that request results in an adverse benefit determination/action, both the provider and the consumer/individual served/guardian will be notified of the adverse benefit determination/action. Notice to the provider can be verbally or in writing. Notice to the consumer/individual served/guardian shall follow written notice requirements as outlined in this policy.
7. If the consumer/individual served/legal representative is not aware of the provider's service request, and the matter warrants involving the consumer/individual served/legal guardian in the request process (i.e., will warrant a change in the Individual Plan of Service (IPOS) that the consumer/individual served/legal representative would need to agree to), CMHSP staff will inform the consumer/individual served/legal representative regarding the request.
8. The PIHP/CMHSP will ensure no retaliatory or punitive action is taken with providers that request an expedited appeal review or support the appeal of a consumer/individual served in any other way.
9. The PIHP/CMHSP may only have one local level of appeal for consumers/individuals served.
10. Individuals served/legal representatives will be informed of their right to request mediation services per MDHHS requirements.

B. Timeliness of Authorization/Service Decisions

1. State and federal regulations require that specific service decisions shall be made within certain time frames. If these times frames (described below) are not met they are considered appealable denials/Adverse Benefit Determinations (ABD) or decisions with grievance rights, and staff shall follow the same processes for providing consumers/individuals served/legal representatives with notices of their appeal or grievance rights as outlined in this policy.
2. Authorization decisions at the initial request for services, or request for hospitalization shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent.
3. Authorization decisions for Medicaid consumers/individuals served currently receiving services shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance for this delay.
4. A standard service authorization decision may be extended an additional 14 calendar days if the consumer/individual served or legal representative requests an extension or if the PIHP/CMHSP/Core Provider justifies a need for additional information and the extension is in the consumer/individual's interest.

5. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ ROSC Core Provider must:
    i. make attempts to give prompt oral/verbal notification of the delay to the individual served/legal representative
    ii. within two calendar days, provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a grievance if he/ she disagrees with that decision;
    iii. issue and carry out the determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).
6. Medicaid covered services shall begin within 14 days from when the authorization was completed, except in cases where the consumer/individual served agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14-day time frame and the consumer/individual served does not agree to an extension, this shall be considered an ABD and staff shall provide the consumer/individual served/legal representative with notice of the denial and their appeal rights.
7. Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/individual served/legal guardian requests, or the PIHP/CMHSP determines that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life or health or ability to attain, maintain, or regain maximum function. In these cases, a decision must be made, and written/electronic notice provided no later than 72 hours from receipt of the request for service.
8. The PIHP/CMHSP may extend the 72-hour time period by up to 14 calendar days if the consumer/individual served/legal representative requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer/individual's interest. If the PIHP/CMHSP extends the timeframe, it must:
    i. give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe,
    ii. inform the consumer/individual served/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and
    iii. make a determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.
9. Consumer/individual served requests for an expedited review of an authorization decision can be denied. If it is denied the consumer/individual served shall receive notice of denial for an expedited review, including the right to file a grievance, and standard 14-day timeframes for an authorization decision shall still be met.
10. If a provider requests an expedited review of an authorization decision, such a request from a provider cannot be denied; the review shall follow the expedited process and the provider shall be informed within 72 hours on whether the service request will be approved or denied.

C. Filing and Timeliness Requirements

1. **Grievances:** A consumer/individual served/legal representative may file a grievance at any time. The PIHP/CMHSP/SUD Core Provider shall resolve grievances and send written notice of the grievance outcome within 60 days of receipt.

2. **Appeals:**

a) Medicaid Appeals: Following receipt of notification of an Adverse Benefit Determination (ABD) by a PIHP/CMHSP/ROSC Core Provider/SUD provider, a consumer/individual served/legal representative has 60 calendar days to request an internal appeal with the entity that provided the ABD. An internal appeal must be resolved within 30 days of receipt.

   i. The 30-day timeframe for an internal appeal may be extended by up to 14 calendar days if a consumer/individual served/legal representative requests an extension or if the CMHSP/PIHP/ROSC Core Provider/SUD provider finds that there is a need for additional information that would be in the best interest of the consumer/individual served. If the timeframe for an internal appeal is extended, the consumer/individual/legal representative must be given notice of the right to file a grievance about the decision.
   ii. A consumer/individual served/legal representative may request a State Fair Hearing within 120 calendar days after receiving notice that the ABD was upheld by the internal appeal.
   iii. If the PIHP/CMHSP does not meet the notice or internal appeal timing requirements, the consumer/individual served has the immediate right to file a State Fair Hearing.

b) Non-Medicaid/General Fund Appeals: Following receipt of an action by the PIHP/CMHSP/ROSC Core Provider, a consumer/individual served/legal representative has 30 calendar days to request a local appeal with the CMHSP. A consumer/individual served/legal representative may request an Alternative Dispute Resolution Process with the state within 10 calendar days after receiving notice that the action was upheld by the local appeal/LDRP.

D. Approved Services

Approval of services is not considered an ABD, and therefore does not require notice of appeal rights. State regulation requires that consumers/individuals served/legal representatives receive an estimated cost of services as part of their Individual Plan of Service.

E. Second Opinion Process

1. All applicants/consumers/individuals served/legal representatives may request a second opinion for a denial of access to services and/or denial of an inpatient psychiatric hospitalization within 30 days of the denial. A second opinion will be provided within the PIHP/CMHSP, at no cost to applicants/consumers/individuals served, by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.
2. All consumers/individuals served may request a second opinion when denied a request for routine/non-urgent/non-emergent service. The CMHSP/PIHP/ROSC Core Provider/contractual provider will ensure a second opinion is provided at no cost to the consumer/individual served, and by a clinical staff that meets the MDHHS criteria for the service in question.
3. Non-urgent requests for a second opinion will be completed for applicants/consumers/individuals served within five (5) business days from the receipt of the request.
4. Upon completion of the second opinion, the applicant/consumer/individual served will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion, and written notification provided within five (5)

business days from the completion of the second opinion.

5. Urgent requests for a second opinion will be provided to consumer/individual served with Medicaid within 72 hours.
6. Urgent requests for a second opinion will be provider to Non-Medicaid consumer/individual served within three (3) business days.
7. Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer/individual served clinical need, and no later than 24 hours of when the service was requested.
8. If the second opinion upholds the original denial, the notification to the applicant/consumer/individual served shall include the next steps available to them, including filing a grievance, and appeal, and/or a recipient rights complaint.
9. If the second opinion reverses the original denial, staff (Access, Psychiatric Emergency Services, or the local designee) shall arrange for services to be provided per the appropriate required timeframes for authorization decisions.

F. Timeliness of Providing Notice of an Adverse Benefit Determination/Adverse Action

Consumers/individuals served/legal representatives shall receive written notice of an ABD/action that meets federal and state requirements for timeliness.

1. Timeliness of Notice for <u>Medicaid</u> Beneficiaries:

a. For a Service Authorization decision that denies or limits services, notice must be provided to the consumer/individual served 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.

b. The CMHSP/PIHP/ROSC Core Provider may be able to extend the standard Service Authorization timeframe up to 14 additional calendar days, if:
   i. The consumer/individual served, or the provider, requests extension; or
   ii. The CMHSP/PIHP/ROSC Core Provider justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer's/individual's interest.

c. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ROSC Core Provider must:
   i. provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served 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 consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

d. Advance Notice of Adverse Benefit Determination is required for service authorization decisions that are reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services. Advance Notice of an ABD must be provided to the consumer/individual served/legal representative at least ten (10) calendar days prior to the proposed effective date.
e. If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP/ROSC Core Provider/SUD provider provider must reinstate services to the level before the action if services have been reduced,

terminated, or suspended.

f. Limited Exceptions to Advance Action Notice of an ABD:
The PIHP may mail an adequate notice of action instead of advance action notice, not later than the date of action to terminate, suspend or reduce previously authorized services, if:

i. The entity providing notice has factual information confirming the death of a consumer/individual served/applicant;
ii. The entity providing notice receives a clear written statement signed by a consumer/individual served/legal representative that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the consumer/individual served/legal representative understands that this must be the result of supplying that information;
iii. The consumer/individual served has been admitted to an institution where he/she is ineligible under the plan for further services;
iv. The consumer/individual's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address;
v. The entity providing notice establishes that the consumer/individual served/applicant 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 consumer/individual's physician;
vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act;
viii. The date of action will occur in less than 10 calendar days.
ix. The entity providing notice has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the consumer/individual served (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

g. If the PIHP/CMHSP/ROSC Core Provider/SUD Provider does not meet the requirements of providing notice or of internal appeal timing requirements, the consumer/individual served with Medicaid has the immediate right to file a State Fair Hearing.

2. Timeliness of Notice for Non-Medicaid/General Funds Consumers Beneficiaries:

a. Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced, whether through a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when there is not an identifiable UR unit, the CMHSP/PIHP/ROSC Core Provider/SUD Provider must inform the consumer/individual served with written notification of the change at least 30 days prior to the effective date of the action.

b. Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

G. Content of Notice

1. Consumers/individuals served/legal representatives shall receive written notice of an

ABD/action with content that meets federal and state requirements.

a. **Content of a Medicaid Notice shall explain the following**:
    i. The ABD the PIHP/CMHSP intends to make or has already made.
    ii. The reasons for the ABD.
    iii. The consumer/individual's right to request an appeal of the PIHP's/CMHSP's ABD, including information on exhausting the PIHP's/CMHSP's one level of appeal and the right to request a State Fair Hearing.
    iv. The right for consumers/individuals served/legal representatives to have an AHR and the timeframes for requesting appeals.
    v. Before and during the appeal, the right of the consumer/individual served/legal representative and/or AHR to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the consumer/individual's ABD. This shall occur in a timely manner sufficient for preparation of their case for the appeal.
    vi. How to submit written comments or information relevant to the appeal.
    vii. The procedure for exercising their appeal rights.
    viii. The circumstances under which an appeal process can be expedited and how to request it.
    ix. The consumer/individual's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the consumer/individual served may be required to pay the cost of these services. A consumer/individual served may be required to pay the cost of the services if:
        1) The decision was upheld.
        2) The consumer/individual served/legal representative/AHR withdraws their appeal request.
        3) The consumer/individual served/legal representative/AHR does not attend the appeal.
    x. Notice of denials given to providers/practitioners shall include information on the opportunity for providers to discuss any denial decision with the reviewer and how to contact the reviewer.

b. **Content of a Non-Medicaid/General Funds Notice** shall explain the following:
    a. A statement of what action the CMHSP intends to take.
    b. The reasons for the intended action.
    c. The specific justification for the intended action.
    d. An explanation of the LDRP.

H. Handling of Appeals:

1. All PIHP/CMHSP/Provider entities handling appeals will:
    a. Ensure that written materials will be provided to consumers/individuals served, legal representatives and AHRs in a language and format that is easily understood.
    b. If an applicant/consumer/individual served requires written materials in alternative formats (i.e., visual/hearing impairments or limited English proficiency), materials will be provided free of charge and in ways to meet their needs. Large print materials must be typed in a font large enough and no less than an 18-point font for the consumer/individual served to read. (See the Regional Customer Services Policy for further information about written materials).
    c. Give consumers/individuals served/legal representatives reasonable assistance in

completing forms and taking other procedural steps related to an appeal. This includes but is not limited to auxiliary aids and services upon request, such as providing free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. This shall occur in accordance with PIHP policies on interpreters and/or limited English proficiency.

2. Any staff/designee handling appeals of ABDs/actions shall:

   a. Acknowledge the receipt of each internal/local appeal in writing within 5 calendar days to the consumer/individual served/legal representative and when applicable, the AHR.
      i. Requests for internal/local appeals received orally will be treated as a formal appeal request to establish the earliest possible filing date for a local appeal.
      ii. An oral request for an appeal will stand as an appeal request. Staff cannot ask or require the requestor of a local appeal to submit any type of written appeal following the oral request for an appeal
      iii. Staff receiving oral requests for an appeal will ensure this request is documented in consumer/individual served and appeals records to ensure compliance with required timeframes are met in both responding to the appeal request and data reporting of appeals.
   b. Ensure that the individuals who make decisions on appeals are individuals who:
      i. Were not involved in any previous level of review or decision making nor a subordinate of any such individual.
      ii. If deciding any of the following, are individuals who have the appropriate clinical expertise in treating the consumer/individual's condition:
         (i) An appeal of a denial that is based on lack of medical necessity.
         (ii) A grievance regarding denial of expedited resolution of an appeal
         (iii) A grievance or appeal that involves clinical issues.
   c. Take into account all comments, documents, records and other information submitted by the consumer/individual served/legal representative without regard to whether such information was submitted or considered in the initial ABD/action.
   d. Provide the consumer/individual served/legal representative a reasonable opportunity, in person or in writing, to present evidence and testimony and make legal and factual arguments. The PIHP/CMHSP must inform the consumer/individual served/legal representative of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and in the case of expedited resolution.
   e. Provide the consumer/individual served/legal representative, upon their request, the consumer/individual's case file, including medical records, other documents, records, and any new or additional evidence considered, relied upon, or generated by the PIHP/CMHSP/Provider in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
      i. The means by which this information is provided will be discussed to ensure they are provided a copy of the case file sufficiently in advance of an appeal resolution, and in accordance with whether the appeal is to be conducted within standard or expedited timeframes.
      ii. Especially in the case of expedited appeals, options such as overnight mail, in-person drop-off, secure email with member permission will be provided.
      iii. In all cases, whether a standard or expedited appeal, documentation of the options discussed and means by which the case file is provided will be

maintained in the appeal record of the CMHPSM EHR Appeals module.

f. Include, as parties to the appeal, the consumer/individual served/legal representative; or the legal representative of a deceased consumer/individual's estate.
g. Ensure Medicaid consumers/individuals served with a Medicaid spend down receive Medicaid notices of appeal. MOAHR, in conjunction with the designated FHO, will determine whether the consumer/individual served had active Medicaid during the time of the decision and is eligible for a State Fair Hearing. If a consumer/individual served with a Medicaid spend down is not eligible for a State Fair Hearing, he/she shall be given the rights to Non-Medicaid appeals processes.
h. Ensure services continue to be provided for consumers/individuals served where applicable during a local/internal or state appeal process without interruption and regardless of the original authorization period if the consumer/individual served requests to continue to receive the services during this process within the required timeframes.
i. Ensure Medicaid consumers/individuals served may continue services, if the appeal request is received within 10 days of the notice of the ABD and includes a written request to continue services. If the ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer/individual served for services provided during the appeal and State Fair Hearing. Recoupment must be consistently applied.
   If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP/Provider must reinstate services to the level before the action if services have been reduced, terminated, or suspended.
   If the PIHP/CMHSP continues or reinstates the consumer/individual's benefits/services, at the consumer/individual's/legal representative's request, while the internal Appeal or State Hearing is pending, the PIHP/CMHSP/Provider must continue those benefits/services until one of the following occurs:
   i. The consumer/individual served/legal representative withdraws the internal appeal or request for State Fair Hearing.
   ii. The consumer/individual served/legal representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP/CMHSP sends the consumer/individual served notice of an adverse resolution to the consumer/individual's/legal representative's internal appeal.
   iii. A State Fair Hearing office issues a decision adverse to the consumer/individual served/legal representative.
j. If the Administrative Law Judge reverses a CMHSP/PIHP/Provider decision to deny, limit, or delay services that were not furnished while the appeal was pending the CMHSP/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.
k. Ensure Non-Medicaid/General Funds may continue at the discretion of the CMHSP until the outcome of the local appeal is completed, if a consumer/individual served requests a local appeal of a reduction, suspension, or termination within 30 days of the date of the notice and in that request includes a written request to continue services. If the local appeal is upheld, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer/individual served for services provided during the local appeal and MDHHS Alternative Dispute Resolution Process. Recoupment must be consistently applied.
l. Ensure that staff provide notice of appeal rights through the use of/entry into the Consumer Notice Module in the regional electronic record, which will generate the

appropriate forms as described in this policy, or use of notice of grievance rights in the Letters module of the regional electronic record. The only exception to this standard is in cases where staff/providers do not have access to the electronic record. In these cases, staff will provide paper/manual notice that meets current state and federal requirements. Resources are available at the PIHP website https://www.cmhpsm.org/sudtraining.

I. Resolution and Notification: General Standards

1. The Internal/Local Appeal Coordinator will follow the receipt process for requests for internal/local appeals.
2. PIHP/CMHSP/Provider person(s) reviewing internal/local appeals will follow processes for conducting internal/local appeals.
3. Review of all internal/local appeals will include:
    a. A full investigation of the substance for the appeal and any aspects of clinical care involved.
    b. The opportunity for the consumer/individual served/legal representative/Authorized Hearing Representative to be present at the internal/local appeal and bring anyone they wish to testify on their behalf.
    c. The opportunity for the consumer/individual served/legal representative to submit written comments, documents, or other information before or during the internal/local appeal meeting.
4. Expedited resolution of internal/local appeals shall be carried out in cases when, by request from the consumer/individual served/legal representative, the PIHP/CMHSP determines or the provider indicates (in making the request on the consumer/individual's behalf or supporting the consumer/individual's request) that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life, physical or mental health or ability to attain, maintain, or regain maximum function.
5. A consumer/individual's request for an expedited appeal can be denied by the PIHP/CMHSP in cases that do not meet the criteria for an expedited appeal.
6. A provider's request for an expedited appeal cannot be denied by the PIHP/CMHSP. In cases where the provider is requesting an expedited appeal the appeal review must be expedited.

J. Medicaid Internal/ Appeal Process:

1. Medicaid internal appeals shall be completed (including the disposition sent out) within 30 calendar days of receipt of the request for an internal appeal with exception of expedited appeals. The 30-day timeframe may be extended by up to 14 calendar days if the consumer/individual served/legal representative request the extension or the PIHP shows that there is need for additional information and the delay is in the consumer/individual's best interest. If the PIHP extends the timeframe not at the request of the consumer/individual served, it must:
    a. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the delay,
    b. Within 2 calendar days give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served/legal representative of the right to file a grievance if he or she disagrees with that decision, and

c. Resolve the appeal as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.

2. **Medicaid Expedited Appeals:** The expedited internal appeals for Medicaid beneficiaries must be resolved and notice of disposition given no later than 72 hours from the request. In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable, based on clinical judgment of a consumer/individual's needs. As with appeals of reductions, suspensions or terminations, the consumer/individual's services will continue until a decision is made, if requested within 10 days of ABD.

a. For expedited resolution of Medicaid internal/local appeals**,** the PIHP/CMHSP may extend the 72-hour notice of disposition time frame by up to 14 calendar days if the consumer/individual served/legal representative requests an extension or, if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the consumer/individual's best interest. (Justification for the extension must be documented).

b. If PIHP, CMHSP, or ROSC Core Provider extends the timeframes not at the request of the enrollee, it must complete all of the following:
   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 he or she disagrees with that decision.
   iii. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

c. If the request for an expedited resolution of a Medicaid internal appeal is denied, the PIHP/CMHSP must:
   i. Transfer the internal appeal to the timeframe for standard resolution or no longer than 30 calendar days from the date the PIHP/ CMHSP received the appeal;
   ii. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/individual served/legal representative written notice of the denial for an expedited appeal within two (2) calendar days;
   iii. Inform the consumer/individual served/legal representative of their right to file a grievance for denial of an expedited appeal.

d. For Medicaid internal appeals, if the CMHSP/PIHP reverses a decision to deny authorization of services that the consumer/individual served received while the appeal was pending, the CMHSP/PIHP must pay for those services

3. **Medicaid Internal Appeal – Notice of Resolution**: A written letter of resolution shall be provided to the consumer/individual served/legal representative/AHR within 30 calendar days of the receipt of the request for internal appeal. The written resolution must include:

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

b. When the appeal is not resolved wholly in favor of the consumer/individual served, the notice of disposition must also include notice of the following:
   i. The consumer/individual's right to request a State Fair Hearing and how to do

so.

ii. The Right to request to receive benefits while the State Fair Hearing is pending and how to make the request.

iii. The potential liability for the cost of those benefits, if the hearing decision upholds the PIHP's ABD.

iv. The right to contact Customer Services or the Office of Recipients Rights.

c. If the consumer/individual served/legal representative continues to receive the service pending the appeal, the consumer/individual served may have to repay the cost of the service. This may happen if:

i. The proposed suspension, reduction or termination of services is upheld in the appeal decision.

ii. The consumer/individual served/legal representative/AHR withdraws their appeal request.

iii. The consumer/individual served/legal representative/AHR does not attend the appeal.

K. Non-Medicaid Local Appeal Process:

1. Non-Medicaid/General Fund local appeals shall be completed within 45 days of the receipt of the request for a local appeal with exception of expedited appeals.

2. Non-Medicaid/General Fund Expedited Appeal

a. If psychiatric inpatient services are denied for Non-Medicaid/General Fund consumers/individuals served, the consumer/individual served/legal representative must be informed of their right to the LDRP, with the decision from that process to be reached within 3 business days.

b. If the CMHSP does not recommend hospitalization and an alternative service requested by the consumer/individual served/legal representative is denied, the CMHSP must inform the consumer/individual served/legal representative of his/her ability to access the LDRP. The decision from that process for these consumers/individuals served must be reached within 3 business days.

c. The CMHSP must communicate the decision of the LDRP and inform the consumer/individual served/legal representative of the right to access the MDHHS Alternative Dispute Resolution Process, if unsatisfied with the outcome of the LDRP.

1. **Non-Medicaid/General Fund Local Appeal – Notice of Resolution:**
At the completion of a LDRP, the CMHSP must provide the consumer/individual served/legal representative written notification of the LDRP decision and subsequent avenues available, if he/she is not satisfied with the result, including the rights of consumers/individuals served without Medicaid coverage to access the MDHHS Alternative Dispute Resolution Process after exhausting the local dispute resolution procedures.

L. State Level Appeal Process:

1. State level appeal processes for Medicaid and Non-Medicaid consumers/individuals served will be followed in accordance with federal and state requirements, per the current Michigan Administrative Hearing System Pamphlet and the MDHHS contract.

2. State Medicaid Fair Hearings:

a. After the internal appeal has been exhausted, a Medicaid consumer/individual served may request a State Fair Hearing, if the PIHP/CMHSP upholds the ABD. If the PIHP/CMHSP does not adhere to the notice and timing requirements in 42CFR 438.408, the consumer/individual served is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.
b. A consumer/individual served must request a State fair hearing not later than 120 calendar days from the date of the PIHP's/CMHSP's notice of resolution.
c. The parties to the State Fair Hearing include the PIHP/CMHSP as well as the consumer/individual served/legal representative or the representative of a deceased consumer/individual's estate.
d. If ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP may recover against the consumer/individual served for services provided during the internal appeal and State Fair Hearing.
e. If the Administrative Law Judge at the State Fair Hearing level reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMHSP/PIHP must authorize, pay for, and/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.

3. Non-Medicaid State Appeals:
   a. After exhausting the local dispute resolution procedures, a Non-Medicaid consumer/individual served may request the MDHHS Alternative Dispute Resolution Process (ADRP) if the CMHSP upholds the action.
   b. A consumer/individual served must request the MDHHS ADRP within 10 days from the written notice of the LDRP outcome.
   c. MDHHS shall review all requests within two business days of receipt.
   d. If MDHHS agrees with the CMHSP/PIHP/Provider decision, the consumer/individual served may be required to pay for the extended services.

M. Family Support Subsidy Appeals

1. All Family Support Subsidy appeals are handled by the local CMHSP.
2. If a Family Support Subsidy Application is denied or services are terminated, the CMHSP will send the consumer/individual's parent or legal representative a memorandum stating the reason for ineligibility and timeline for an appeal.
3. If the parent or representative had an income increase that resulted in the family exceeding the statutory limit, and the parent or representative did not notify the CMH within two weeks of the change, the CMHSP shall send the parent or representative a memorandum explaining that the subsidy will be terminated, and any amount illegally received will be repaid together with interest as provided in Administrative Rule 330.1621. Repayment of these services will be arranged through the state FSS program.
4. The parent/legal representative has 60 days to file an appeal from the date of the notice of ineligibility or termination. This may be done by letter or by a local Non-Medicaid appeal form available from the local CMHSP.
   If the parent/legal representative requests an FSS appeal within 60 days, the CMHSP shall conduct an FSS hearing in the manner provided for a contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969

5. Using a “reasonable person” standard, the CMHSP determines if the denial or termination of the subsidy will pose an immediate and adverse impact upon the consumer/individual’s health and safety. If so, the CMHSP hears the appeal within one business day. If not, the CMHSP follows the steps below.
    a. Sends parent or legal representative notice of receipt of appeal, indicating the following information about the scheduled hearing:

        i. Date, hour, place, and nature of hearing.
        ii. Statement of legal authority and jurisdiction under which the hearing is to be held.
        iii. Reference to statues and rules involved, and
        iv. Short and plain statement of the matters asserted.
        v. If the timeline for an appeal was exceeded, sends a response indicating that the appeal was not received within two months of the action, and no further appeal rights are warranted.

N. Record Keeping and Retention Requirements:

1. PIHPs shall ensure the maintenance of records for second opinions, local appeals, and copies of State appeals. The PIHP must review the information as part of its ongoing monitoring procedures. The record of each appeal must contain, at a minimum, all of the following information:
    a. If the consumer/individual served is a Medicaid beneficiary or is served with Non-Medicaid/General Funds.
    b. A general description of the reason for the appeal.
    c. The date and time the appeal was received.
    d. Date and type of adverse benefit determination associated with the appeal.
    e. Whether ABD timeframes were met in providing notice
    f. Service(s) related to the appeal.
    g. Date of the service request; if an expedited appeal is request the time of the request needs to also be included.
    h. Whether an expedited appeal review was requested
    i. Whether and expedited appeal request was approved or denied.
    j. Whether expedited appeal timeframes were met (where applicable)
    k. The date of each review or, if applicable, review meeting.
    l. Evidence that individuals who made the decisions on appeals were not involved in any previous level of review or decision making, nor are subordinates of any such individual.
    m. Resolution at each level of the appeal, if applicable, including whether original ABD was upheld or not, in full or in part.
    n. Date and time of resolution at each level, where applicable.
    o. Name of the covered person for whom the appeal was filed.
    p. If the person had an AHR, and the name of the AHR where applicable.
    q. Whether the Medicaid beneficiary involved is using or has used at least one LTSS service at any point during the reporting year.
    r. Whether the Medicaid beneficiary is enrolled in a health home
2. All CMHSP and CMHPSM staff will use the CMHPSM EHR Appeals Module for all documentation of appeals records, data, and the provision of appeal-related notices/ letters to persons served, legal guardians, and/or AHRs.
3. Appeal records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

4. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

O. Performance Improvement

1. Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, LDRC requests/resolutions, MOAHR Administrative Hearing requests/resolutions, and MDHHS Alternative Dispute Resolution requests/resolutions. This information will be reported and reviewed by the PIHP UM Committee quarterly and maintained by the PIHP Compliance/Quality Manager.
2. Quarterly aggregate reports of appeals data shall be provided by the PIHP Compliance Manager /PIHP Utilization Management Committee Chair to the PIHP Clinical Performance Team and the PIHP Customer Services Committee as the PIHP Quality Assurance and Performance Improvement Program (QAPIP) entity for their review and recommendations on any trends or improvement opportunities.
3. The PIHP Compliance/Quality Manager will ensure PIHP reporting of service denial decisions, local/internal appeals, and grievances to MDHHS in accordance with the current MDHHS/PIHP contract.

VII. PROCEDURES

CMHPSM Procedure for Documentation of Appeals

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
Medicaid Managed Care Rule 42 CFR Parts 432, 433, 438 et al.	X	
Michigan Mental Health Code Act 258 of 1974 as amended	X	Section 100b,409(4),705
MDHHS/PIHP Medicaid Contract and Attachments	X	4.4.1.1 Person Centered Planning Practice Guideline; 6.3.1.1 Grievance & Appeal Technical Requirement Process
MDHHS Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings.	X	
MDHHS/CMHSP General Funds Contract	X	3.1.1 Access System Standards; 6.3.2.1 CMHSP Local Dispute Resolution Process; 6.3.2.2 Family Support Subsidy Program
Family Support Subsidy Act, Public Act 249 of 1983, as amended.	X	
Administrative Procedures Act of 1969, Public Act 306 of 1969	X	Sec. 24.271-24.287.

MDHHS Administrative Rules	X	
MDHHS Policy Hearing Authority Decision #01-0358CMH, and subsequent MDHHS clarifications	X	
CMHPSM Office of Recipient Rights Policy	X	
CMHPSM Culturally and Linguistically Relevant Services Policy	X	
CMHPSM /Limited English Proficiency Policy	X	
CMHPSM Utilization Management Policy	X	
CMHPSM Customer Services Policy	X	
MI Medicaid Provider Manual	X	Coordination of Benefits Chapter; Behavioral Health and Intellectual and Developmental Disabilities Supports & Services Chapter
MOAHR Administrative Hearings Pamphlet	X	
Section 942 of PA 268 of 2016	X	