

<b>PIHP Policy for the COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN</b>	<b><i>Policy and Procedure</i></b>		
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<b>Administrative Signature:</b>		<b>Date:</b>	
<b>Board of Directors Signature:</b>		<b>Date:</b>	

**I. PURPOSE**

To establish policy and procedures to receive and resolve consumer 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. APPLICATION**

All regional staff of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), all Community Mental Health Service Provider (CMHSP) staff, students and volunteers, all Recovery Oriented System of Care (ROSC) Core Providers, and contractual providers.

**III. 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 shall have a designee to handle internal/local appeals until:

- a. A Medicaid consumer requests a State Fair Hearing with the Michigan Administrative Hearing System (MAHS) after receiving notice that an adverse benefit determination (ABD) was upheld by the Local Dispute Resolution Committee (LDRC).
- b. A Medicaid consumer initiates a State Fair Hearing with the MAHS, because the PIHP/CMHSP failed to adhere to the notice and timing requirements. (When this occurs, a consumer is deemed to have exhausted the internal appeals processes).
- c. A Non-Medicaid consumer completes the 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 MAHS 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 by the PIHP and its region 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 and providers
6. Cost and resource efficient
7. Subject to quality improvement review

These processes shall:

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

## IV. DEFINITIONS

Access Staff - Staff designated to provide intake and/or assessment of an applicant's/consumer'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 client 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/ 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/legal representative that a service is being suspended, reduced, or terminated. For Medicaid consumers, this notice must be mailed at least 10 days before the effective date of the service change. For Non-Medicaid consumers, 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.
4. The 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 service request.
5. The failure to make an expedited service authorization within 72 hours after receipt of a request for expedited service authorization.
6. 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.
7. The failure of a PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request.
8. The failure of a PIHP/CMHSP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
9. 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.
10. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer's request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.
11. The denial of a consumer's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other consumer financial liabilities.

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 - An individual, 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 (or the consumer's legal representative) to stand in for or represent the consumer during a local/internal or state level appeal, or a representative/parent of a minor, or the consumer's spouse, widow, or widower, if there is no one else with authority to represent the consumer.

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 - An individual 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 clients 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.

Expedited Appeal - The prompt review of an ABD or action, requested by a consumer/legal representative or a provider on behalf of the consumer, when the time necessary for the normal/standard review process could seriously jeopardize the consumer's life or health or ability to attain, maintain or regain maximum function. If the consumer/legal representative requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the consumer's provider makes the request, or supports the consumer'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. Grievances not completed according to time frames are also considered a Medicaid ABD and are appealable.

Grievance Process - Impartial local level review of a consumers' 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.

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 under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, 1915(c), Children's Waiver Program, and/or B3/Additional Service Section 1915(b)(3) of the Social Security Act.

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 Administrative Hearing System (MAHS) - 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 as described in *42 CFR 438.408*.

Recipient Rights Complaint - A written or verbal statement by a consumer or anyone acting on behalf of a consumer alleging a violation of a consumer'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 MAHS 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.

## **V. STANDARDS**

### **A. General Standards**

1. Grievance and Appeal System: Processes shall be in place for consumers and promote the resolution of concerns as well as support and enhance the goal of improving the quality of services.

2. Consumers/legal representatives shall be informed of their right to access the 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/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 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.
5. Providers, acting on behalf of a consumer/applicant and with the consumer's/legal representative's written consent, may file an appeal as the consumer's Authorized Hearing Representative (AHR).
6. If an external/contractual provider makes a service request on behalf of a consumer, and that request results in an adverse benefit determination/action, both the provider and the consumer/guardian will be notified of the adverse benefit determination/action. Notice to the provider can be verbally or in writing. Notice to the consumer/guardian shall follow written notice requirements as outlined in this policy.
7. If the consumer/legal representative is not aware of the provider's service request, and the matter warrants involving the consumer/legal guardian in the request process (i.e. will warrant a change in the Individual Plan of Service (IPOS) that the consumer/legal representative would need to agree to), CMHSP staff will inform the consumer/legal representative regarding the request.
8. Level of Appeals: The PIHP/CMHSP may only have one level of appeal for consumers.

## **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 time frames (described below) are not met they are considered denials/Adverse Benefit Determinations and staff shall follow the same processes for providing consumers/legal representatives with notices of their appeal rights as all other denials/Adverse Benefit Determinations.
2. Authorization decisions at the initial request for services, or request for hospitalization shall be made within 14 days of when



- the consumer, 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 currently receiving services shall be made within 14 days of when the consumer, 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.
  4. A standard service authorization decision may be extended an additional 14 calendar days if the consumer 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's interest. If the PIHP/CMHSP/Core Provider extends the timeframe, it must give the consumer/legal representative written notice of the reason for the decision to extend the timeframe, inform the consumer/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and make a determination as expeditiously as the consumer's health condition requires and no later than the date the extension expires.
  5. Medicaid covered services shall begin within 14 days from when the authorization was completed, except in cases where the consumer agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14-day time frame and the consumer does not agree to an extension, this shall be considered an ABD and staff shall provide the consumer/legal representative with notice of the denial.
  6. Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/legal guardian requests, or the PIHP/CMHSP determines that following the standard timeframe could seriously jeopardize the consumer/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.
  7. The PIHP/CMHSP may extend the 72-hour time period by up to 14 calendar days if the consumer/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's interest. If the PIHP/CMHSP extends the

timeframe, it must give the consumer/legal representative written notice of the reason for the decision to extend the timeframe, inform the consumer/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and make a determination as expeditiously as the consumer's health condition requires and no later than the date the extension expires.

8. Consumer requests for an expedited review of an authorization decision can be denied; if it is denied the consumer shall receive notice of denial for an expedited review and standard 14-day timeframes for an authorization decision shall still be met.
9. 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/legal representative may file a grievance at any time.
2. Appeals:
  - a) Medicaid Appeals: Following receipt of notification of an Adverse Benefit Determination (ABD) by a PIHP/CMHSP, a consumer/legal representative has 60 calendar days to request an internal appeal with the PIHP/CMHSP. An internal appeal must be resolved within 30 days of receipt. This timeframe may be extended by up to 14 calendar days a consumer/legal representative requests an extension or if the CMHSP/PIHP finds that there is a need for additional information that would be in the best interest of the consumer.

A consumer/legal representative may request a State Fair Hearing within 120 calendar days after receiving notice that the ABD was upheld by the internal appeal.

If the PIHP/CMHSP does not meet the notice or internal appeal timing requirements, the consumer has the immediate right to file a State Fair Hearing.

- b) Non-Medicaid/General Fund Appeals: Following receipt of an action by the CMHSP, a consumer/legal representative has 30 calendar days to request a local appeal with the CMHSP. A consumer/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. Providing Notice of Approved Services**

1. State regulation requires that consumers/legal representatives receive notice of their appeal/hearing rights when services are approved at the onset of services and during the person-centered planning process.

#### **E. Second Opinion Process**

1. All applicants/consumers/legal representatives may request a second opinion for a denial of access to services and of access to hospitalization within 30 days of the denial. A second opinion will be provided within the PIHP/CMHSP at no extra cost to applicants/consumers by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.
2. Non-urgent requests for a second opinion will be completed for applicants/consumers within five (5) business days from the receipt of the request.
3. Urgent requests for a second opinion will be provided within two (2) business days.
4. Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer clinical need, and no later than 24 hours of when the service was requested.
5. Upon completion of the second opinion, the applicant/consumer will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion; this notification will be followed by a written notification within five (5) business days from the completion of the second opinion.
6. If the second opinion upholds the original denial, the notification to the applicant/consumer shall include the next steps available to them, including filing a recipient rights complaint.
7. 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**

1. Consumers/legal representatives shall receive written notice of an ABD/action that meets federal and state requirements for timeliness.
2. Timeliness of Notice for Medicaid Beneficiaries:
  - a. For a Service Authorization decision that denies or limits services, notice must be provided to the consumer 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, 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 interest.
  - c. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ROSC Core Provider must:
    - (iii) provide the consumer written notice of the reason for the decision to extend the timeframe and inform the consumer of the right to file a Grievance if he or she disagrees with that decision; and
    - (vi) issue and carry out its determination as expeditiously as the consumer'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/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 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, not later than the date of action to terminate, suspend or reduce previously authorized services, if:
  - i. The CMHSP/PIHP has factual information confirming the death of a consumer/applicant;
  - ii. The CMHSP/PIHP receives a clear written statement signed by a consumer/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/legal representative understands that this must be the result of supplying that information;
  - iii. The consumer has been admitted to an institution where he/she is ineligible under the plan for further services;
  - iv. The consumer's whereabouts are unknown and the post office returns agency mail directed to him/her indicating no forwarding address;
  - v. The CMHSP/PIHP establishes that the consumer/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's physician;
  - vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;
  - viii. The date of action will occur in less than 10 calendar days.
  - ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the consumer (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 does not meet the requirements of providing notice or of internal appeal timing requirements, the consumer has the immediate right to file a State Fair Hearing.

3. 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 must inform the consumer with written notification of the change at least 30 days prior to the effective date of the action.
- a. 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/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'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/legal representatives to have an AHR and the timeframes for requesting appeals.
- v. Before and during the appeal, the right of the consumer/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'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'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 may be required to pay the cost of these services. A consumer may be required to pay the cost of the services if:

1. The decision was upheld.
2. The consumer/legal representative/AHR withdraws their appeal request.
3. The consumer/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 entities will:
  - a. Ensure that written materials will be provided to consumers, legal representatives and AHRs in a language and format that is easily understood.
  - b. If an applicant/consumer 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 individual to read. (See the Regional Customer Services Policy for further information about written materials).
  - c. Give consumers/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/legal representative and when applicable, the AHR. 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. An oral appeal must be confirmed in writing unless the applicant/consumer, legal representative/provider requests expedited resolution of an appeal.
  - 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'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/legal representative without regard to whether such information was submitted or considered in the initial ABD/action.



- d. Provide the consumer/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/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/legal representative the consumer's case file, including medical records, other documents, records, and any new or additional evidence considered, relied upon, or generated by the PIHP/CMHSP in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- f. Include, as parties to the appeal, the consumer/legal representative; or the legal representative of a deceased consumer's estate.
- g. Ensure Medicaid consumers with a Medicaid spend down receive Medicaid notices of appeal. MAHS, in conjunction with the designated FHO, will determine whether the consumer had active Medicaid during the time of the decision and is eligible for a State Fair Hearing. If a consumer 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 where applicable during a local/internal or state appeal process without interruption and regardless of the original authorization period, if the consumer requests to continue to receive the services during this process within the required timeframes.
- i. Ensure Medicaid consumers 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 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 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's benefits, at the consumer's/legal representative's request, while the internal Appeal or State Hearing is pending, the PIHP/CMHSP must continue benefits until one of the following occurs:

  - i. The consumer/legal representative withdraws the internal appeal or request for State Fair Hearing.
  - ii. The consumer/legal representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the

PIHP/CMHSP sends the consumer notice of an adverse resolution to the consumer's/legal representative's internal appeal.

- iii. A State Fair Hearing office issues a decision adverse to the consumer/legal representative.
- j. If the Administrative Law Judge 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 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 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 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. 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.

#### **G. Resolution and Notification: Internal/Local Level Appeal Process:**

1. The Internal/Local Appeal Coordinator will follow the receipt process for requests for internal/local appeals.
2. PIHP/CMHSP 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/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/legal representative to submit written comments, documents, or other information before or during the internal/local appeal meeting.

4. 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/legal representative request the extension or the PIHP shows that there is need for additional information and the delay is in the consumer's best interest. If the PIHP extends the timeframe not at the request of the consumer, it must:
  - a. Make reasonable efforts to give the consumer/legal representative prompt oral notice of the delay,
  - b. Within 2 calendar days give the consumer/legal representative written notice of the reason for the decision to extend the timeframe and inform the consumer/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's health condition requires and no later than the date the extension expires.
5. 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.
6. Expedited resolution of local appeals shall be carried out in cases when, by request from the consumer/legal representative, the PIHP/CMHSP determines or the provider indicates (in making the request on the consumer's behalf or supporting the consumer's request) that following the standard timeframe could seriously jeopardize the consumer/applicant's life, physical or mental health or ability to attain, maintain, or regain maximum function.
7. 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's needs. As with appeals of reductions, suspensions or terminations, the consumer's services will continue until a decision is made, if requested within 10 days of ABD.
8. 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/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's best interest. (Justification for the extension must be documented).
9. If the request for an expedited resolution of a Medicaid internal appeal is denied, the PIHP/CMHSP must:
    - a. 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;
    - b. Make reasonable efforts to give the consumer/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/legal representative written notice of the denial for an expedited appeal within two (2) calendar days;
    - c. Inform the consumer/legal representative of their right to file a grievance for denial of an expedited appeal.
  10. For Medicaid internal appeals, if the CMHSP/PIHP reverses a decision to deny authorization of services that the consumer received while the appeal was pending, the CMHSP/PIHP must pay for those services.
  11. Non-Medicaid/General Fund Expedited Appeal
    - a. If psychiatric inpatient services are denied for Non-Medicaid/General Fund consumers, the consumer/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/legal representative is denied, the CMHSP must inform the consumer/legal representative of his/her ability to access the LDRP. The decision from that process for these persons must be reached within 3 business days.
    - c. The CMHSP must communicate the decision of the LDRP and inform the consumer/legal representative of the right to access the MDHHS Alternative Dispute Resolution Process, if unsatisfied with the outcome of the LDRP.
  12. Medicaid Internal Appeal – Notice of Resolution: A written letter

of resolution shall be provided to the consumer/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, the notice of disposition must also include notice of the following:
    - i. The consumer'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/legal representative continues to receive the service pending the appeal, the consumer 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/legal representative/AHR withdraws their appeal request.
    - iii. The consumer/legal representative/AHR does not attend the appeal.
13. Non-Medicaid/General Fund - Notice of Resolution: At the completion of a LDRP, the CMHSP must provide the consumer/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 without Medicaid coverage to access the MDHHS Alternative Dispute Resolution Process after exhausting the local dispute resolution procedures.

## **J. State Level Appeal Process:**

1. State level appeal processes for Medicaid and Non-Medicaid/General Fund consumers will be followed in accordance with federal and state

requirements, per the current Michigan Administrative Hearing System Pamphlet and the MDHHS contract.

## 2. Medicaid:

- a. After the internal appeal has been exhausted, a Medicaid consumer 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 is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.
- b. A consumer 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/legal representative or the representative of a deceased consumer's estate.
- d. If ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP may recover against the consumer 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/General Fund:

- a. After exhausting the local dispute resolution procedures, a Non Medicaid/General Fund consumer may request the MDHHS Alternative Dispute Resolution Process if the CMHSP upholds the action.
- b. A consumer must request the Local Dispute Resolution Process 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, the consumer may be required to pay for the extended services.

## **K. 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'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.
5. 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
6. 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'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 statutes 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.

#### **L. Record Keeping Requirements:**

- a. 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:
  - i. A general description of the reason for the appeal.
  - ii. The date and time the appeal was received.
  - iii. Whether an expedited appeal review was requested
  - iv. The date of each review or, if applicable, review meeting.
  - v. 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.
  - vi. Resolution at each level of the appeal, if applicable.
  - vii. Date and time of resolution at each level, where applicable.
  - viii. Name of the covered person for whom the appeal was filed.
- b. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

#### **M. Performance Improvement**

- 1. Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, LDRC requests/resolutions,



MAHS 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 provided to the PIHP Director of Quality and Compliance quarterly.

2. Quarterly aggregate reports of appeals data shall be provided by the PIHP Director of Quality and Compliance/PIHP Utilization Management Committee Chair to the PIHP Clinical Performance Team as the PIHP Quality Assurance and Performance Improvement Program (QAPIP) entity for their review and recommendations on any trends or improvement opportunities.

## VI. REFERENCES

<b>Reference:</b>	<b>Check if applies:</b>	<b>Standard Numbers:</b>
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	X	

Relevant Services Policy		
CMHPSM Cultural Competency/Limited English Proficiency Policy	X	
CMHPSM Utilization Management Policy	X	
CMHPSM Customer Services Policy	X	
MI Medicaid Provider Manual	X	Behavioral Health and Intellectual and Developmental Disabilities Supports & Services Chapter
MAHS Administrative Hearings Pamphlet	X	
Section 942 of PA 268 of 2016	X	