



NMRE ADMINISTRATIVE MANUAL

SUBJECT Beneficiary Grievance and Appeal	ACCOUNTABILITY	Effective Date: February 27, 2019	Pages: 4
REQUIRED BY	BBA Section: 81 CFR 27853, 42 CFR 430-481, Social Security Act 1902(a)(3) and (4) and 1932(b)(4) PIHP Contract Section: II 6.3.1 (P.6.3.1.1) Other:	Last Review Date: August 24, 2023	Past Review Date: May 8, 2023
Policy: <input checked="" type="checkbox"/> Procedure: <input type="checkbox"/>	Review Cycle: Annual Author: Customer Services Specialist	Responsible Department: Quality & Customer Services	Reviewers: Customer Services

Definitions

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

- a. Denial or limited authorization of a requested services, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. [42 CFR 438.400(b)(1)]
- b. Reduction, suspension, or termination of a previously covered service. [42 CFR 438.400(b)(2)]
- c. Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)]
- d. Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for services. [42 CFR 438.210(d)(1)]
- e. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. [42 CFR 438.210(d)(2)]
- f. Failure to provide services within 14 calendar days of the start date agreed upon during person-centered planning and as authorized by the PIHP. [42 CFR 438.400(b)(4)]
- g. Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. [42 CFR 438.408(b)(2)]
- h. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. [42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3)]
- i. Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. [42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)]
- j. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a beneficiary's request to exercise his/her right under §438.52(b)(2)(ii) to obtain services outside the

network. [42 CFR 438.400(b)(6)]

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

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

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

Appeal: A review at the local level by the PIHP of an Adverse Benefit determination, as defined above. (42 CFR 438.400)

Authorization of Services: The processing of request for initial and continuing service delivery. [42CFR438.210(b)]

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative. For the purposes of this policy, the terms "beneficiary" and "member" may be used interchangeably.

CMHSP: Community Mental Health Services Provider. For the purposes of this document, a CMHSP member is one or more of the following: AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority.

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

Grievance: Beneficiary's expression of dissatisfaction about PIHP/Network Provider issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the beneficiary, failure to respect the beneficiary's rights regardless of whether remedial action is requested, or a beneficiary's dispute regarding an extension of time proposed by the PIHP to make a service authorization decision. (42 CFR 438.400)

Grievance Process: Impartial local review of a beneficiary's grievance.

Grievance and Appeal System: The process the PIHP implements to handle appeals of Adverse benefit Determinations and grievances, as well as the process for collecting and tracking information about them. (42 CFR 438.400)

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel.

Northern Michigan Regional Entity (NMRE): Northern Michigan Regional Entity/Region 2 PIHP covering Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle Roscommon, and Wexford counties in northern Lower Michigan.

Notice of Resolution: Written statement of the PIHP of the resolution of a grievance or appeal, which must be provided the beneficiary as within 30 calendar days in the case of a standard appeal, 72 hours in the case of an expedited appeal, 90 days in the case of a standard grievance, unless the criteria for an extension have been met. (42 CFR 438.408)

Prepaid Inpatient Health Plan (PIHP): A term contained in federal regulations from the Centers for Medicare & Medicaid Services. It means an entity that 1) provides medical services to enrollees under contract with the state Medicaid agency based on prepaid capitation payments, 2) includes responsibility for arranging inpatient hospital care, and 3) does not have a comprehensive risk contract.

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

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

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

SUD Provider Network: Refers to a substance use disorder provider that is directly under contract with the PIHP to provide services and supports.

Purpose

The Purpose of this policy is to allow beneficiaries to dispute adverse actions whenever their benefits are denied, reduced, or terminated, or to voice any disagreements, complaints, or dissatisfaction related to the provision of publicly funded behavioral health or substance use disorder services.

Policy

The NMRE Beneficiary Grievance and Appeal Policy will comply with the most recent version of the MDHHS Appeal and Grievance Resolution Processes Technical Requirement, the NMRE's Specialty Supports and Services Contract with the State, and all required rules, laws, and regulations including:

- (1) Section 1902(a)(3) of the Social Security Act which requires that a State Plan provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
- (2) Section 1902(a)(4) of the Social Security Act which requires that the State Plan provides for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
- (3) Section 1932(b)(4) of the Social Security Act which requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalfs, may challenge the denial of coverage of, or payment for, medical assistance.

Approval Signature

A handwritten signature in black ink, appearing to read "Eric Rung", is written over a horizontal line.

NMRE Chief Executive Officer

8/24/23

Date

SUBJECT Beneficiary Grievance and Appeal	ACCOUNTABILITY	Effective Date: February 27, 2019	Pages: 8
REQUIRED BY	BBA Section: 81 CFR 27853, 42 CFR 430-481, Social Security Act 1902(a)(3) and (4) and 1932(b)(4) PIHP Contract Section: II 6.3.1 (P.6.3.1.1) Other:	Last Review Date:	Past Review Date:
Policy <input type="checkbox"/>	Review Cycle: Annual	Responsible Department:	Reviewers:
Procedure <input checked="" type="checkbox"/>	Author: Customer Svcs. Specialist	Quality & Customer Services	Brie Molaison, Customer Services

General Requirements

A. The grievance and appeal system

The NMRE will have a grievance and appeal system in place for beneficiaries.

B. Level of appeals

The NMRE will have only one level of appeal for beneficiaries.

C. Filing requirement

A beneficiary may file a grievance and request an appeal with the NMRE. A beneficiary may request a State Fair Hearing after receiving notice (under §438.408) that an adverse benefit determination is upheld.

1. If the notice and timing requirements set forth in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408 are not met, the beneficiary is deemed to have exhausted the NMRE's appeals process. The beneficiary may initiate a State Fair Hearing.
2. The State may offer and arrange for an external medical review if the following conditions are met.
 - a. The review must be at the beneficiary's option and must not be required before or used as a deterrent to proceed with the State Fair Hearing.
 - b. The review must be independent of both the State and the NMRE.
 - c. The review must be offered without any cost to the beneficiary.
 - d. The review must not extend any of the timeframes specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408 and must not disrupt beneficiary's continuation of benefits.

With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a State Fair Hearing, on behalf of a beneficiary.

D. Timing

1. A beneficiary may file a grievance with the NMRE at any time.
2. Following receipt of a notification of an adverse benefit determination, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal.

E. Procedures

1. The beneficiary may file a grievance either orally or in writing and, as determined by the State, either with the State or with the NMRE.
2. The enrollee may request an appeal either orally or in writing. Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

Handling of grievances and appeals

A. General requirements

In handling grievances and appeals, the NMRE will give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. Special requirements

The NMRE's process for handling beneficiary grievances and appeals of adverse benefit determinations will:

1. Acknowledge receipt of each grievance and appeal within 5 business days.
2. Ensure that the individuals who make decisions on grievances and appeals are individuals:
 - a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
 - b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease.
 - i. An appeal of a denial that is based on lack of medical necessity.
 - ii. A grievance regarding the denial of an expedited resolution of an appeal.
 - iii. A grievance or appeal that involves clinical issues.
 - c. Who considers all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
3. Guarantee that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

4. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The NMRE must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(b) and (c) in the case of expedited resolution.
5. Provide the beneficiary and their representative with the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the NMRE (or at the direction of the NMRE) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in The NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(b) and (c).
6. Include, as parties to the appeal:
 - a. The beneficiary and their representative; or
 - b. The legal representative of a deceased beneficiary's estate.

Resolution and notification: Grievances and appeals

A. Basic rule

The NMRE will resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

B. Specific timeframes

1. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the NMRE receives the grievance.
2. For standard resolution of an appeal and notice to the affected parties, the State has established a timeframe that is no longer than 30 calendar days from the day the NMRE receives the appeal. This timeframe may be extended under paragraph (C) of this section.
3. For expedited resolution of an appeal and notice to affected parties, the State has established a timeframe that is no longer than 72 hours after the NMRE receives the appeal. This timeframe may be extended under paragraph (C) of this section.

C. Extension of timeframes

1. The NMRE may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if:
 - a. The beneficiary requests the extension; or
 - b. The NMRE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.

2. If the NMRE extends the timeframes not at the request of the beneficiary, it must:
 - a. Make reasonable efforts to give the beneficiary prompt oral notice of the delay. Oral notice does not negate the need for written notice.
 - b. Within 2 calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with that decision.
 - c. Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
3. In the case that the NMRE fails to adhere to the notice and timing requirements in this section, the beneficiary is deemed to have exhausted the NMRE's appeals process. The beneficiary may initiate a State Fair Hearing.

D. Format of notice

1. The State has established the method that the NMRE will use to notify a beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.10.
2. Appeals:
 - a. For all appeals, the NMRE will provide written notice of resolution in a format and language that, at a minimum, is easily understood and readily accessible. Notice of resolution will be provided in, or interpreter services will be provided to, a beneficiary with limited English proficiency or limited reading proficiency, or in large print, TTY/TDD format as the beneficiary's needs determine, consistent with the standards described in 42 CFR 438.10.
 - b. For notice of an expedited resolution, the NMRE will also make reasonable efforts to provide oral notice.

E. Content of notice of appeal resolution

The written notice of the resolution must include the following:

1. The results of the resolution process and the date it was completed.
2. For appeals not resolved wholly in favor of the beneficiary:
 - a. The right to request a State Fair Hearing, and how to do so.
 - b. The right to request and receive benefits while the hearing is pending, and how to make the request.
 - c. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the adverse benefit determination.

F. Requirements for State Fair Hearings

1. A beneficiary may request a State Fair Hearing only after receiving notice that the NMRE is upholding the adverse benefit determination.

- a. In the case that the NMRE fails to adhere to the notice and timing requirements in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR§438.408, the beneficiary is deemed to have exhausted the NMRE's appeals process. The beneficiary may initiate a State Fair Hearing.
- b. The State may offer and arrange for an external medical review if the following conditions are met.
 - i. The review must be at the beneficiary's option and must not be required before or used as a deterrent to proceed with the State Fair Hearing.
 - ii. The review must be independent of both the State and the NMRE.
 - iii. The review must be offered without any cost to the enrollee.
 - iv. The review must not extend any of the timeframes specified in 42 CFR 438.408 and must not disrupt the continuation of benefits in 42 CFR 438.420, as stated in The NMRE Beneficiary Grievance and Appeal Policy.
2. The beneficiary must request a State Fair Hearing no later than 120 calendar days from the date of the NMRE's Notice of Resolution.
3. The parties to the State Fair Hearing include the NMRE as well as the beneficiary and their representative, or the representative of a deceased enrollee's estate.

Expedited resolution of appeals

A. General rule

The NMRE will establish and maintain an expedited review process for appeals, when the NMRE determines (for a request from the enrollee) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

B. Punitive action

The NMRE will ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.

C. Action following denial of a request for expedited resolution

If the NMRE denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. Prompt oral notice must be given to the beneficiary. If a prompt oral notice is not provided, a written notice must be given within 2 days. These elements are in accordance with the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(b)(2).

Information about the grievance and appeal system to providers and subcontractors

Recordkeeping requirements

- A. The State requires that the NMRE maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring procedure as well as for updates and revisions to the State quality strategy.
- B. The record of each grievance or appeal must contain, at a minimum, all the following information:
 - 1. A general description of the reason for the appeal or grievance.
 - 2. The date received.
 - 3. The date of each review or, if applicable, review meeting.
 - 4. Resolution at each level of the appeal or grievance, if applicable.
 - 5. Date of resolution at each level, if applicable.
 - 6. Name of the covered person for whom the appeal or grievance was filed.
- C. The record must be accurately maintained in a manner accessible to the state and available upon request to the Centers for Medicare and Medicaid Services.
- D. The record must be kept for at least 10 years.

Continuation of benefits while the NMRE appeal and the State fair hearing are pending

A. Definition

As used in this section

- 1. **Timely files:** Files for continuation of benefits on or before the later of the following:
 - a. Within 10 calendar days of the NMRE sending the notice of adverse benefit determination.
 - b. The intended effective date of the NMRE's proposed adverse benefit determination.

B. Continuation of benefits

The NMRE will continue the beneficiary's services if all the following occur:

- 1. The beneficiary files the request for an appeal in accordance with the timelines specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.402(c)(2)(ii);
- 2. The appeal involves the termination, suspension, or reduction of previously authorized services;
- 3. The services were ordered by an authorized provider;
- 4. The period covered by the original authorization has not expired; and
- 5. The beneficiary timely files for continuation of benefits.

C. Duration of continued or reinstated benefits

If, at the beneficiary's request, the NMRE continues or reinstates the beneficiary's services while the

appeal or State Fair Hearing is pending, benefits must be continued until one of following occurs:

1. The beneficiary withdraws the appeal or request for state fair hearing.
2. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the NMRE sends the notice of an adverse resolution to the beneficiary's appeal in accordance with the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(d)(2).
3. A State Fair Hearing office issues a hearing decision adverse to the enrollee.

E. Enrollee responsibility for services furnished while the appeal or State Fair Hearing is pending

If the final resolution of the appeal or State Fair Hearing is adverse to the beneficiary, that is, upholds the NMRE's adverse benefit determination, the NMRE will, consistent with the state's usual policy on recoveries under 42 CFR 431.230(b) and as specified in the NMRE's Specialty Supports and Services Contract with the State, recover the cost of services furnished to the beneficiary while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

Effectuation of reversed appeal resolutions.

A. Services not furnished while the appeal is pending

If the NMRE, or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the NMRE will authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

B. Services furnished while the appeal is pending

If the NMRE or the State Fair Hearing Officer reverses a decision to deny the authorization of services, and the beneficiary received the disputed services while the appeal was pending, the NMRE, or the State must pay for those services, in accordance with State policy and regulations.

Approval Signature



NMRE Chief Executive Officer

8/24/23

Date