NORTHCARE NETWORK

POLICY TITLE: Enrollee Grievance & Appeal Process	**CATEGORY:** Customer Services	
EFFECTIVE DATE: 6/26/02	**BOARD APPROVAL DATE:** 1/30/13	
REVIEW DATE: 11/28/22	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Customer Services Specialist/QI Coordinator	**CEO APPROVAL DATE:** 12/6/22 Dr. Tim Kangas, CEO	

APPLIES TO

NorthCare Network Personnel
Network Providers

POLICY

It is the policy of NorthCare Network that individuals receiving Medicaid Specialty Supports and Services have the right to a fair and efficient process for resolving disagreements regarding their services and supports. To achieve this outcome, NorthCare Network has adopted the current MDHHS Appeal and Grievances Resolution Processes Technical Requirements. NorthCare Network is responsible for informing Enrollees' receiving Access Services/Screenings and community inpatient care of their appeal rights. The responsibility for providing a comprehensive grievance and appeal process at the CMHSP service level has been delegated to the five (5) Member CMHSPs. Each Member CMHSP will have policy and procedures in accordance with NorthCare policy and the MDHHS Grievance and Appeal Technical Requirements in order to fulfill this requirement.

PURPOSE

This policy is intended to facilitate NorthCare Network and its providers' compliance with the grievance and appeals processes required by the State of Michigan and the federal government for Enrollees' receiving services funded by NorthCare Network.

DEFINITIONS

1. **Adverse Benefit Determination:** A decision that adversely impacts the Medicaid Enrollee's claim for services due to: (42 CFR 438.400) See *Notice of Adverse Benefit Determination Policy.*

2. **Enrollee:** A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Manager (PCCM), or Primary Care Case Management (PCCM) Entity in a managed care program.

3. **Expedited Appeal:** This type of appeal is available after a request from the Enrollee and/or provider (in making a request on behalf of the Enrollee) states that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If this expedited appeal request is denied the Enrollee must be provided the reason why within 2 calendar days. If the expedited appeal is granted, the appeal must be resolved and notice of resolution must be provided to parties affected within 72 hours from the time the expedited appeal request is received.

4. ***Grievance System*** as used in this policy is the definition given in the regulations implementing the Balanced Budget Act of 1997 (BBA). The Grievance system is the overall system of Enrollee grievance and appeals. Conceptually, the grievance system divides Enrollee dissatisfaction into two categories.
    - Those challenging an "adverse benefit determination" as defined in the federal regulations and in the MDHHS Appeal and Grievances Resolution Technical Requirement. A challenge to an adverse benefit determination is called an **appeal. OR**
    - Those dissatisfied with anything else is considered a **grievance.** The Code of Federal Regulations, 42 CFR, section 438.400(b)(7) states: Grievances may include but are not limited to the quality of care of the services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or the failure to respect the Enrollees' rights regardless of whether remedial is requested.

    In Michigan, this has led to confusion as to the relationship of recipient rights outlined in the Michigan Mental Health Code to the federal requirements. However, the definition given in the federal regulations supports viewing the **appeal process** as the mechanism whereby Medicaid Enrollees' would address any concerns regarding a specific **adverse benefit determination** taken by a provider. There are two different types of appeals that can be requested – an expedited appeal or a standard appeal.

5. **Grievance process** would be used to address any Enrollee complaints or recipient rights complaints. Medicaid and MDHHS require tracking of all grievances and appeals to demonstrate the effectiveness of Enrollee education and protection of an Enrollees' rights.

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

7. **Standard Appeal:** The appeal must be resolved and notice of resolution provided to parties affected within 30 calendar days from the day the appeal is received.

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

REFERENCES

- The Federal Balanced Budget Act of 1997
- 42 CFR Chapter IV, Subpart E, sections 431.200 *et seq*
- 42 CFR Chapter IV, Subpart A, section 438.2
- 42 CFR Chapter IV, Subpart F, sections 438.402 to 424
- Michigan Mental Health Code, Act 258 of the Public Acts of 1974 as Amended Michigan PA 516 of 1996
- MDHHS/PIHP Contract, Policies & Practices Guidelines https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.ht786ml
- NorthCare Network Service Authorization Policy
- NorthCare Network Notice of Adverse Benefit Determination Policy

HISTORY

REVISION DATE: 3/15/07, 6/7/09, 1/30/13, 9/12/13, 8/27/14, 4/26/17, 1/25/18, 11/27/18, 1/21/19, 6/25/19, 9/30/21,11/28/22
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BOARD APPROVAL DATE: 2/23/05, 1/30/13

PROCEDURES

A. Education

1. Medicaid-Enrollees:
   a) Enrollees will be informed of PIHP/Provider internal grievance and appeal rights and procedures at the time of the initial application for services and throughout their care. Initial and ongoing education of the enrollee's grievance and appeals rights and process is the responsibility of NorthCare Network and each Network Provider.
   b) The PIHP/Provider Internal Grievance and Appeals procedures will be included in the Member Handbook and provided to each Enrollee upon admission to service, offered annually and provided upon request.
   c) Enrollees will be provided assistance in completing forms and in taking procedural steps if assistance is requested and/or needed. There may be no charge to the Enrollee for any aspect of the appeal process including payment for a second opinion by an independent reviewer. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. Staff/Providers:
   a) Staff responsible for educating enrollees and carrying out responsibilities for processing grievances and appeals must have proper training and support.
   b) All Providers will be given a copy of PIHP/Provider Grievance and Appeals Policy(ies) at time of onboarding and when updated or new policy is adopted.

B. Due Process

1. Medicaid Enrollees – Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "Due Process" whenever their Medicaid benefits are denied, reduced, or terminated. Due Process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision measured from the date the complaint is first made. Nothing about managed care changes these Due Process requirements. The Medicaid Enrollee Appeal and Grievance Resolution Process provides a process to help protect the Medicaid Enrollee Due Process rights.

   Consumers of mental health services, who are Medicaid Enrollees eligible for specialty supports and services, have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act (SSA) and its federal regulations that articulate federal requirements regarding appeals and grievances for Medicaid beneficiaries who participate in managed care:
   - Local grievances through authority of 42 CFR 438.400 et seq.

- The PIHP appeals through authority of 42 CFR 438.400 et seq.
- State Fair Hearings through authority of 42 CFR 431.200 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the Michigan Mental Health Code (MMHC), Chapters 7,7A, 4, and 4A, including:

- Recipient Rights complaints through authority of the MMHC (MCL 330.1772 et seq.).
- Medical Second Opinion through authority of the MMHC (MCL 330.1705 and 42 CFR 438.206(b)(3).)

2. Non-Medicaid Enrollees – Grievances and appeals filed by non-Medicaid consumers will be handled by the provider according to provider's local dispute resolution process.

C. General Requirements

1. NorthCare and each provider will identify staff responsible for all aspects of the grievance, appeals and state fair hearing processes, as applicable to their organizations. It will be the responsibility of both parties to keep each other informed of the responsible staff name(s) and contact information as changes are made.
2. Identified staff are responsible for meeting timelines as required.
3. Every effort must be made to provide notices written at a 6.9 grade reading level.
4. The Grievance and Appeals System must provide:
   a) Only one [local] level for appeal which enables Enrollees to challenge Adverse Benefit Determinations (ABD) made by the PIHP or its agents. An Enrollee may request a State Fair Hearing (SFH) after receiving notice that the ABD is upheld.
   b) A Grievance process which enables Enrollees to seek resolution to issues that are not Adverse Benefit Determinations (42 CFR 438.228).
   c) The right to concurrently file an Appeal of an ABD and a Grievance regarding other service complaints.
   d) Access to the State Fair Hearing (SFH) process to further appeal and ABD, after receiving notice that the ABD has been upheld by the PIHP level Appeal.
   e) Information that if the PIHP fails to adhere to notice and timing requirements as outlined in the Appeal process, the Enrollee is deemed to have exhausted the PIHPs Appeal process and the Enrollee may initiate a SFH.
   f) The right to request and have Medicaid covered benefits continued while the PIHP Appeal and/or SFH is pending.
   g) With written consent from the Enrollee, the right to have a provider or other authorized representative acting on the Enrollee's behalf file an Appeal or Grievance to the PIHP or request a SFH. The provider may file a Grievance or request a State Fair Hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

D. Notice of Adverse Benefit Determination – The PIHP/Provider must give Enrollees timely and adequate notice of an Adverse Benefit Determination in writing consistent with requirements consistent with requirements in 438.02, 438.10, 438.404, the MDHHs/PIHP Contract, and NorthCare Policy titled – Notice of Adverse Benefit Determinations and can be found on our website at: www.northcarenetwork.org

E. Medicaid Services Continuation or Reinstatement

1. If an Appeal involved the termination, suspension, or reduction of previously authorized services, the PIHP/provider MUST continue the Enrollee's benefits if all of the following occur (42 CFR 438.420):
    a) The Enrollee files the request for Appeal timely (w/in 60 calendar days from the date on the ABD notice); 42 CFR 438.402(c)(2)(ii)
    b) The services were ordered by an authorized Provider.
    c) The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of ABD or (ii) the intended effective date of the proposed ABD. 42 CFR 438.402(a); and
    d) The period covered by the original authorization has not expired.
2. Duration of Continued or Reinstated Benefits (42 CFR 438.420(c). If the PIHP/Provider continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or SFH is pending, the PIHP/Provider must continue the benefits until one of the following occurs.
    a) The Enrollee withdraws the Appeal or SFH.
    b) The Enrollee fails to request a SFH and continuation of benefits within 10 calendar days after the PIHP/Provider sends the Enrollee notice of and adverse resolution to the Enrollee's Appeal.
    c) A SFH office issues a decision adverse to the Enrollee.
    d) The authorization expires or authorization service limits are met [MDHHS Contract L.5.(i)(iv)].
3. If the final resolution of the Appeal or SFH upholds the PIHP/Providers ABD, the PIHP/Provider may, per contract stipulations, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d)*
4. If the Enrollee's services were reduced, terminated, or suspended without an advance notice, the PIHP/Provider must reinstate services to the level before the action.
5. If the PIHP/Provider or the SFH Administrative Law Judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP/Provider must pay for those services
6. If the PIHP/Provider or the State Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PIHP/Provider must authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, **but no later than 72 hours** from the date it receives notice reversing the determination. *42 CFR 438.424(a)*

F. Appeal Process

1. Upon receipt of an ABD, an Enrollee may request an internal [local] review by the PIHP/Provider, which is the first of two Appeal levels, under the following conditions:
   a) The Enrollee must request an appeal within 60 calendar days from the date on the ABD notice. 42 CFR 438.402 (c)(2)(ii)
   b) Enrollee my request an Appeal either orally or in writing. 42 CFR 438.402 (c)(3)(ii). Oral inquiries seeking to Appeal and ABD will be treated as Appeals and this inquiry date will establish the date of filing as an Appeal.
   c) In circumstances above, see "Continuation of Benefits".
2. PIHP/Provider Responsibilities when Enrollee Requests and Appeal:
   a) Provide Enrollee reasonable assistance to complete forms and with process.
   b) Acknowledge receipt of each Appeal in writing within five (5) calendar days of receipt of request.
   c) Maintain a record of Appeals.
   d) Ensure that the individual(s) who make the decision(s) on Appeals:
      i. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
      ii. When deciding an Appeal that involves clinical issues or a denial based on lack of medical necessity are individual(s) who have the appropriate clinical expertise in treating the Enrollee's conditions or disease.
      iii. Consider all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether it was submitted or considered in the initial ABD.
   e) Provide the Enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing, and inform the Enrollee if the limited time available for this sufficiently in advance of the resolution timeframe for Appeals in the case of Expedited Appeal resolution.
   f) Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP/Provider, in connection with the Appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals. Every effort will be made to mail this information within 2 business days of request.
   g) Provide opportunity to include as parties to the Appeal the Enrollee and his/her representative or the legal representative of a deceased Enrollee's estate.
   h) Provide the Enrollee with information regarding the right to request a SFH and the process to be used to request one.
3. Appeal Resolution Timing and Notice Requirements
   a) Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but **not to exceed 30 calendar days** from the day the PIHP receives the Appeal. In the event an Enrollee consents to a representative acting on their behalf, the 30-calendar daytime frame begins on the date an authorized representative's consent is received by the PIHP/Provider.
   b) Expedited Appeal Resolution (timing): If the request for an expedited Appeal is granted, the PIHP/Provide must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but **not to exceed 72 hours** from the date/time of the

receipt of the Expedited Appeal. Reasonable efforts to provide oral notice must be made and documented.

i. Expedited Appeals are available where the PIHP/Provider determines (by request from the Enrollee) or the provider indicates (in making a request on Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

ii. The PIHP/Provide may not take punitive action against a provider/staff who requests an expedited resolution or supports the Enrollee's Appeal.

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

- Make reasonable efforts to give Enrollee prompt oral notice of denial and document attempts and/or oral notice in ELMER G&A module.
- Within 2 calendar days, give Enrollee written notice of the reason to extend timeframe and inform of right to file a grievance if they disagree with decision to extend.
- Transfer Appeal timeframe to standard resolution.
- Resolve the Appeal as expeditiously as possible, but no later than 30 calendar days from decision to extend.

4. Extension of Timeframes: The PIHP/Provider may extend the standard or expedited resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP/Provider determines there is a need for additional information, and how the delay is in the Enrollee's interest.
   a) If the PIHP/Provider extends resolution/notice timeframes, not at the request of the Enrollee, it must complete all the following:
      i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay and document in ELMER G&A module.
      ii. Within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe, and inform them of the right to file a Grievance if they disagree with the decision to extend.
      iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires, and not later than the date the extension expires.
5. Appeal Resolution Notice Format and Content: The Resolution Notice format and content must include specific elements that are built into the ELMER G&A module and are based on templates provided and required by MDHHS.

G. Grievance Process

1. An Enrollee, guardian, or parent of a minor child, or his/her legal representative may file a Grievance at any time with the PIHP/Provider's staff/unit responsible for facilitating resolution of Grievances, either orally or in writing.
2. Access to the State Fair Hearing (SFH) process in respect to Grievances is only available when the PIHP/Provider fails to resolve the Grievance and provide resolution **within 90 calendar days** of the date the grievance is received. This constitutes an "Adverse Benefit Determination" (ABD) and can be appealed to the Michigan Administrative Hearing System (MAHS) using the SFH process.
3. PIHP/Provider Responsibility when Enrollee Files a Grievance:
   a) Provide Enrollee reasonable assistance to complete forms and with process.
   b) Acknowledge receipt of each Grievance in writing within five (5) calendar days of receipt of request.
   c) Maintain a record of Grievance.

d) Submit the written Grievance to appropriate staff including PIHP/Provider administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination.
e) Ensure individual(s) who make the decision on the Grievance:
    i. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual.
    ii. When the Grievance involves either clinical issues or denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise in treating the Enrollee's conditions or disease.
    iii. Consider all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial review(s).

4. Grievance Resolution Timing and Notice Requirements
    a) Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP/Provider received the Grievance.
    b) Extension of Timeframes: The PIHP/Provider may extend the Grievance resolution and notice timeframe by up to 14 calendar days if the Enrollee requests and extension, or if the PIHP/Provider determines a need for additional information and how the delay is in the Enrollee's interest.
        i. If the PIHP/Provider extends resolution/notice timeframes, not at the request of the Enrollee, it must complete all the following:
            - Make reasonable efforts to give the Enrollee prompt oral notice of the delay and document in ELMER G&A module.
            - Within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe, and inform them of the right to file a Grievance if they disagree with the decision to extend.
            - Resolve the Grievance as expeditiously as the Enrollee's health condition requires, and not later than the date the extension expires.
5. Grievance Resolution Notice Format and Content: The Resolution Notice format and content must include specific elements that are built into the ELMER G&A module and are based on templates provided and required by MDHHS.

H. State Fair Hearing Appeal Process

1. Federal regulations provide the Enrollee the right to an impartial review by a State-level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:
    a) After receiving notice, the PIHP/Provider is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1)*
    b) When the PIHP/Provider fails to adhere to the notice and timing requirements for resolution of Appeals and Grievances, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*
2. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to the Enrollee, independent of the State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii)*

3. The PIHP/Provider may not limit or interfere with the Enrollee's freedom to make a request for a State Fair Hearing.
4. The Enrollee is given up to **120 calendar days** from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing.
5. The PIHP/Provider is required to continue benefits if the conditions described under Medicaid Services Continuation or Reinstatement section are satisfied and for the durations described therein.
6. If the Enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP/Provider must reinstate services to the level before the Adverse Benefit Determination.
7. The parties to the State Fair Hearing include the Enrollee and his/her representative, or the representative of a deceased Enrollee's estate, and the PIHP.
8. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
9. Expedited hearings are available.

I. Documentation and Recordkeeping

1. A record of each Appeal and Grievance is required and must contain a minimum set of data noted below. Each Appeal and Grievance will be documented in the ELMER Grievance & Appeal module by PIHP/Provider identified responsible staff. Minimum data includes:
    a) A general description of the reason for the Appeal or Grievance
    b) The date received
    c) The date of each review or review meeting
    d) The resolution at each level of Appeal or Grievance, if applicable
    e) The date of the resolution at each level, if applicable
    f) Name of covered Enrollee for whom the Appeal or Grievance was filed
2. Records must be accurate and timely and accessible to the State and available upon request to CMS.
3. Letter templates as well as the ABD notice are designed and available in ELMER and must be utilized.
4. PIHP/Provider must provide written notice of resolution in a format and language that, at minimum. Meets the standard described in accordance with 42 CFR 438.10.
5. Grievance and 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. This standard supersedes NorthCare's record retention policy.

J. Monitoring and Reporting

NorthCare monitors timeliness for ABDs and resolution of both Appeals and Grievances. Data is reviewed over time for any patterns or trends that may identify issues and/or opportunities for improvement with an individual provider or process or systemic issues. Aggregate data is also reviewed with NorthCare's Quality Management Committee and the Regional Customer Services Committee. NorthCare is also required to report event level data to MDHHS on a quarterly data which is also used for random select for case file reviews during annual program audits and ongoing monitoring of timeliness by MDHHS.