NORTHCARE NETWORK

POLICY TITLE: Enrollee Grievance & Appeal Process	**CATEGORY:** Customer Services	
EFFECTIVE DATE: 6/26/02	**BOARD APPROVAL DATE:** 1/30/13	
REVIEW DATE: 9/27/24	**REVISION(S) TO POLICY STATEMENT:** ☒ **Yes** ☐ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Customer Services Specialist	**CEO APPROVAL DATE:** 10/1/24 Megan Rooney, CEO	

APPLIES TO

NorthCare Network Personnel
Network Providers

POLICY

It is the policy of the PIHP, NorthCare Network, that a due process system is established, maintained and in compliance with federal and state regulations to ensure all Medicaid beneficiaries the right to a fair and efficient process for resolving disagreements regarding their services and supports. An individual, or applicant for, public mental health services may access several options to pursue the resolution of disagreements. This system includes both mental health and substance use disorder services and treatments. It is the policy of NorthCare Network to follow all state and federal regulations regarding the resolution of complaints and disputes individuals may have about their services and supports. Individuals receiving Medicaid Specialty Supports and Services have the right to a fair and efficient process for resolving disagreements regarding their services and supports.

This policy and any corresponding policies in no way requires the beneficiary to utilize due process prior to filing a Recipient Rights complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code and affiliate policies related to the filing of Recipient Rights complaints. This is also true for the Recipient Rights process for Substance Use Disorder services.

PURPOSE

This policy is intended to establish the position statement of NorthCare Network regarding adherence and compliance with the regulatory requirements for the public behavioral health Prepaid Inpatient Health Plan (PIHP). Further it is intended to ensure 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)
    - *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. 42 CFR 438.400 (b)(1).*

- *Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).*
- *Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3)*
- *Failure to make a standard Service Authorization decision and provide notice about the decision within fourteen calendar days from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).*
- *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).*
- *Failure to provide services within fourteen calendar days of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. 42 CFR 438.400(b)(4); 42 CFR 438.20.*
- *Failure of the PIHP to resolve standard appeals and provide notice within thirty calendar days from the date the standard appeal request is received by the PIHP. l. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
- *Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date the expedited appeal request is received by the PIHP. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*
- *Failure of the PIHP to resolve grievances and provide notice within ninety calendar days the grievance is received by the PIHP. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*
- *For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise the enrollees' rights under § 438.52(b)(2)(ii), to obtain services outside the network. 42 CFR 438.400(b)(6).*
- *Denial of an Enrollee's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. 42 CFR 438.400(b)(7).*

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

3. ***Advance Notice of Adverse Benefit Determination****: A written statement advising the enrollee of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided to the Medicaid enrollee at least 10 days prior to the proposed date the adverse benefit determination takes effect. (42 CFR 438.400(c)(1);42 CFR 431.211)*

4. ***Appeal:*** *A review at the local level by the PIHP of an Adverse Benefit Determination. (42 CFR 438.400(b)).*

5. ***Authorization of Services****: The processing of requests for initial and continuing service delivery. (42 CFR 438.210(b))*

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

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

8. ***Expedited Appeal:*** *The expeditious review of an Adverse Benefit Determination, requested by the enrollee or the enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, the PIHP determines if the request is warranted. If the enrollee's provider makes the request, or supports the enrollee's request, the PIHP must grant the request. (42 CFR 438.410(a); 42 CFR 438.210)*

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

10. ***Grievance Process****: Impartial local level review of the enrollee's Grievance.*

11. ***Grievance and Appeal System****: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. (42 CFR 438.400)*

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

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

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

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

16. ***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. MHC 330.1776*

17. ***Service Authorization****: The PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in*

an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

18. ***State Fair Hearing****: Impartial state-level review of the Medicaid enrollee's appeal of an Adverse Benefit Determination presided over by a Michigan Office of Administrative Hearings and Rules (MOAHR)*

19. ***Administrative Law Judge****. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431 (431.200 – 431.246).*

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

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

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/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines
- 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, 9/27/24
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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 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 each Network Provider and NorthCare Network.
    b) The PIHP 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 helped in completing forms and in taking procedural steps if assistance is requested and/or needed. There will 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 fulfilling responsibilities for processing grievances and appeals must have proper training and support.
   b) All Providers will be given a copy of PIHP Grievance and Appeals Policy 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:
   a) Prior written notice of the adverse action.
   b) A fair hearing before an impartial decision maker.
   c) Continued benefits pending a final decision; and
   d) 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

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.

According to 42 CFR 438.408, each PIHP must resolve each grievance and appeal, and provide notice, as quickly as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in 42 CFR 438.408.

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 (3) processes under the 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:

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

This policy does not describe the recipient rights process.

C. General Requirements

1. An Appeal process (one level only) enables enrollees the right to challenge Adverse Benefit Determinations made by the PIHP or its agents.

2. A Grievance process.

3. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints.

4. Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.

5. Information that if the PIHP fails to adhere to notice and timing requirements as outlined in the PIHP Appeal process, the enrollee is deemed to have exhausted the PIHPs Appeal process. The enrollee may initiate a State Fair Hearing.

6. The right to request and have Medicaid covered benefits continued while the PIHP Appeal and/or the State Fair Hearing is pending.

7. With the written consent from the enrollee, the right to have a provider or other authorized representative acting on the enrollee's behalf file an Appeal or Grievance to the PIHP or request a State Fair Hearing. The provider may file a Grievance or request a State Fair Hearing on behalf of the enrollee since the State permits the provider to act as the enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the enrollee's behalf with the enrollee's written consent to do so.

D. Medicaid Benefits and Services Continuation or Reinstatement

1.Continuation of benefits:

a) The PIHP must continue the enrollee's benefits if all the following occur (42 CFR 438.420(b)):
   i. The enrollee files the request for an appeal timely within sixty calendar days from the date on the Adverse Benefit Determination Notice. (42 CFR 438.420(b)(1); 42 CFR 438.402(c)(ii))
   ii. ii.The enrollee files for continuation of benefits timely (on or before the latter of within ten (10) calendar days of the PIHP sending the notice of Adverse Benefit Determination; or the intended effective date of the proposed Adverse Benefit Determination. (42 CFR 438.420(b)(5); 42 CFR 438.420(a.
   iii. The Appeal involves the termination, suspension, or reduction of previously authorized services (42 CFR 438.420(b)(2)).
   iv. iv The services were ordered by an authorized provider (42 CFR 438.420(b)(3));
   v. The period covered by the original authorization request has not expired (42 CFR 438.420(b)(4)); and

2. Duration of Continued or Reinstated Benefits (42 CFR 438.420(c)):
   If the PIHP continues or reinstates the enrollee's benefits, at the enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:
   a) The enrollee withdraws the Appeal or request for State Fair Hearing. (42 CFR 438.420(c)(1))
   b) The enrollee fails to request a State Fair Hearing and continuation of benefits within ten calendar days after the PIHP sends the enrollee notice of an adverse resolution to the enrollee's Appeal under 42 CFR 438. 408(d)(2). (42 CFR 438.420(c)(2))
   c) The State Fair Hearing office issues a decision adverse to the enrollee. (42 CFR 438.420(c)(3))

3. Enrollee responsibility for services furnished while the appeal or state fair hearing is pending:
   If the final resolution of the Appeal or State Fair Hearing upholds the PIHPs Adverse Benefit Determination, the PIHP may, consistent with the State's usual policy on recoveries under 42 CFR 431.230(b), and as specified in the PIHP contract, recover the cost of services furnished to the enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. (42 CFR 438.420(d))

4. Reinstating services:
   If the enrollee's services were reduced, terminated, or suspended without an advance notice, the PIHP must reinstate services to the level before the action. (42 CFR 431.231(c))

5. Services furnished while the appeal is pending:
   If the PIHP or the State Fair Hearing Administrative Law Judge reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. (42 CFR 438.424(b))

6. Services not furnished while the appeal is pending:
   If the PIHP or the State Fair Hearing Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. (*42 CFR 438.424(a))*

E. Appeal Process

1 Upon receipt of an ABD, federal regulations 42 CFR 400 et. Seq. provides the enrollee the right to Appeal the determination through an internal review by the PIHP. Each PIHP may only have only one level of appeal. The enrollee may request an internal review by the PIHP, which is the first of two Appeal levels, under the following conditions:
   a. The Enrollee must request an appeal within sixty 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). Note: Oral inquiries seeking to Appeal and Adverse Benefit Determination are treated as appeals (to establish the earliest possible filing date for the Appeal). (42 CFR 438.406(b)(3)).

c. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services while the appeal or state fair hearing is pending, until one of the events described in that section occurs. (*42 CFR 438.420(c))*

2. PIHP Responsibilities when the Enrollee Requests Appeals:
   a) The PIHP must provide the enrollee any reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (*42 CFR 438.406(a))*
   b) The PIHP must acknowledge receipt of each standard Appeal within five (5) business days. (*42 CFR 438.406(b)(1); 42 CFR 438.408(b)(3))*
   c) The PIHP must maintain a record of appeals for review by the State as part of its quality strategy*. (42 CFR 438.416(a))*
   d) The PIHP must ensure that the individual(s) who make the decisions on appeals are individuals:
      i. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual (*42 CFR 438.406(b)(2)(i*)).
      ii. Who when deciding an Appeal that involves either involves clinical issues, or a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease *(42 CFR 438.406(b)(2)(ii))*; and
      iii. Consider all comments, documents, records, and other information submitted by the enrollee and/or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. *(42 CFR 438.406(b)(2)(iii))*
   e) The PIHP must provide the enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. The PIHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals. (*42 CFR 438.406(b)(4))*
   f) The PIHP must provide the enrollee and the enrollee's representative the enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP, in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. (*42 CFR 438.406(b)(5))*
   g) The PIHP must provide opportunity to include as parties to the Appeal the enrollee and the enrollee's representative or the legal representative of a deceased enrollee's estate. (*42 CFR 438.406(b)(6*))
   h) The PIHP must provide the enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one. The enrollee can request a State Fair Hearing only after receiving notice that the PIHP is upholding the Adverse Benefit Determination (*42 CFR*

438.408(f)(1)). In the case of a PIHP that fails to adhere to the notice and timing requirements of **30 days,** the enrollee is deemed to have exhausted the PIHP's appeals process. The enrollee may initiate a State fair hearing *(42 CFR 438.408(c)(3)).*

3. 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 **thirty calendar days** from the day the PIHP receives the Appeal. (*42 CFR 438.408(b)(2)*
    b) Expedited Appeal Resolution (timing):
        i. Each PIHP must establish and maintain an expedited review process for appeals when the PIHP determines (for a request from the enrollee) or the provider indicates (in making a request on the enrollee's behalf or supporting the enrollee's request) that the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (*42 CFR 438.410(a))*
        ii. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports the enrollee's Appeal. (*42 CFR 438.410(b))*
    c) If a request for expedited resolution of an appeal is denied, the PIHP must:
        i. Transfer the Appeal to the timeframe for standard resolution. (*42 CFR 438.410(c)(1))*
        ii. Make reasonable efforts to give the enrollee prompt oral notice of the denial if the PIHP extends the timeframes not at the request of the enrollee. (*42 CFR 438.408, 438.410(c)(2))*
        iii. Within **two (2) calendar days**, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision. (*42 CFR 438.408(c)(2); 438.410(c)(2))*
        iv. Resolve the Appeal as expeditiously as the enrollee's health condition requires, but not to exceed **thirty calendar days**. (*42 CFR 438.408(c)(2)(iii))*
    d) If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72 hours** after the PIHP receives the request for expedited resolution of the Appeal. *(42 CFR 438.408(b)(3))*

4. Extension of Timeframes:
    The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the enrollee requests an extension; or if the PIHP shows (to the satisfaction of the State, upon its request) that there is a need for additional information, and how the delay is in the enrollee's interest. (*42 CFR 438.408(c)(1))*
    a.) If the PIHP extends resolution/notice timeframes not at the request of the enrollee, it must complete **all** the following (*42 CFR 438.408(c)(2)):*
        i. Make reasonable efforts to give the enrollee prompt oral notice of the delay. *(42 CFR 438.408(c)(2)(i))*

ii. Within **2 calendar days**, give the enrollee written notice of the reason for the decision to extend the timeframe, and inform the enrollee of the right to file a Grievance if they disagree with the decision. (*42 CFR 438.408(c)(2)(ii))*
iii. Resolve the Appeal as expeditiously as the enrollee's health condition requires, and not later than the date the extension expires. *(42 CFR 438.408(c)(2)(iii))*

5. Appeal Resolution Notice Format:
The PIHP must provide enrollees with written notice of the resolution of their appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. (*42 CFR 438.408(d)(2)*
   a) The enrollee notices must meet the requirements of *42 CFR 438.10(c)(1) that states "each PIHP entity must provide all required information* in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," and meets the needs of those with limited English proficiency and/or limited reading proficiency.
   b) Provider agencies must utilize the templates for ABDs provided by NorthCare Network.

6. Appeal Resolution Notice Content:
   a) The notice of resolution must include the results of the resolution process and the date it was completed. (*42 CFR 438.408(e)(1))*
   b) When the Appeal is not resolved in favor of the enrollee, the notice of disposition must also include:
      i. The enrollee's right to request a State Fair Hearing, and how to do so. *(42 CFR 438.408(e)(2)(i))*
      ii. The enrollee's right to request to receive benefits while the State Fair Hearing is pending, and how to make the request *(42 CFR 438.408(e)(2)(ii))*; and
      iii. That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's adverse benefit determination. (*42 CFR 438.408(e)(2)(iii))*

F. Grievance Process

1. Federal regulations provide the enrollee the means of expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the PIHP to make an authorization decision. (*42 CFR 438.400(b) "Grievance")*

2. Generally:
   a) The enrollee must file a Grievance with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

b) A Grievance may be filed at any time by the enrollee, guardian, or parent of a minor child, or the enrollee's authorized representative. *(42 CFR 438.402(c)(1)(ii); 42 CFR 438.402(c)(2)(i))*

3. PIHP Responsibility when Enrollee Files a Grievance:
    a) The PIHP must provide the enrollee any reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (*42 CFR 438.406(a))*
    b) Acknowledge receipt of the Grievance **within five (5) business days**. (*42 CFR 438.406(b)(1))*
    c) Maintain a record of Grievances for review by the State as part of its quality strategy. (42 CFR 438.416(a))
    d) Ensure that the individual(s) who make the decisions on the Grievance are individuals:
        i. Who was neither involved in any previous level review or decision-making, nor a subordinate of any such individual. (*42 CFR 438.406(b)(2)(i))*
        ii. Who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues. (42 CFR 438.406(b)(2)(ii))
        iii. Who considers all comments, documents, records, and other information submitted by the enrollee and/or the enrollee's representative without regard to whether such information was submitted or considered previously. (42 CFR 438.406(b)(2)(iii))

4. Grievance Resolution Timing and Notice Requirements
    a) Timing of Grievance Resolution:
    Provide the enrollee a written notice of resolution not to exceed **ninety calendar days** from the day the PIHP received the Grievance. (42 CFR 438.408(b)(1))
    b) Extension of Timeframes:
    The PIHP may extend the Grievance resolution and notice timeframe by up to **fourteen calendar days** if the enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the enrollee's interest. (*42 CFR 438.408(c))*
        i. If the PIHP extends resolution/notice timeframes 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. (*42 CFR 438.408(c)(2)(i))*
            - Within **2 calendar days**, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision. (*42 CFR 438.408(c)(2)(ii))*

c) Format and Content of Notice of Grievance Resolution:
    i. The enrollee notices must meet the requirements of *42 CFR 438.10(c)(1)* that states *"each PIHP entity must provide all required information in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees,"* and meets the needs of those with limited English proficiency and/or limited reading proficiency.
    ii. The notice of Grievance resolution must include:
        - The results of the Grievance process.
        - The date the Grievance process was concluded.

G. State Fair Hearing Process

1. Federal regulations provide the enrollee the right to an impartial review by a State-level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:
    a) After receiving notice that the PIHP is upholding an Adverse Benefit Determination after Appeal. *(42 CFR 438.408(f)(1)).*
    b) When the PIHP fails to adhere to the notice and timing requirements for resolution of appeals as described in *42 CFR 438.408(f)(1)(i).*

2. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions are met:
    a) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing. (*42 CFR 438.408(f)(1)(ii)(A))*
    b) The review must be independent of both the State and the PIHP. *(42 CFR 438.408(f)(1)(ii)(B))*
    c) The review must be offered without any cost to the enrollee. *(42 CFR 438.408(f)(1)(ii)(C))*
    d) The review must not extend any of the timeframes specified above and must not disrupt the continuation of benefits. (*42 CFR 438.408(f)(1)(ii)(D))*

3. The PIHP may not limit or interfere with the enrollee's freedom to make a request for a State Fair Hearing.

4. The enrollee is given **no more than 120 calendar days** from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing. (*42 CFR 438.408(f)(2))*

5. The PIHP is required to continue benefits if the conditions described in *Section VII - Medicaid Services Continuation or Reinstatement* are satisfied and for the duration described therein.

6. If the enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination. (*42 CFR 431.231(c))*

7. The parties to the State Fair Hearing include the enrollee and the enrollee's representative, or the representative of a deceased enrollee's estate, and the PIHP. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities. (*42 CFR 438.408(f)(3))*

8. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Office of Administrative Hearings and Rules Fair Hearing process can be found on the MDHHS website at:
https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/resources/michigan-office-of-administrative-hearings-and-rules-for-michigan-department-of-health-and-human-se