MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral & Physical Health & Aging Services Administration

APPEAL AND GRIEVANCE RESOLUTION PROCESSES TECHNICAL REQUIREMENT

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I. PURPOSE AND BACKGROUND

This Technical Requirement is intended to facilitate the Prepaid Inpatient Health Plans (PIHPs) compliance with the Appeal and Grievance Resolution Process requirements contained in the Medicaid Managed Specialty Supports and Services Contract with the Michigan Department of Health and Human Services (MDHHS). The requirements can be found in Schedule A, Statement of Work; 1. General Requirements; Section L. Grievance and Appeals Process for Beneficiaries. These requirements are applicable to all the PIHPs, the Community Mental Health Services Programs (CMHSPs), and their provider networks.

Although this Technical Requirement specifically addresses the federal Grievance and Appeal System Processes required for Medicaid enrollees, other dispute resolution processes available to all mental health consumers are identified and referenced.

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.

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.*

This guide does not describe the recipient rights process.

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

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 **14 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 **14 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 **30 calendar days** from the date the standard appeal request is received by the PIHP. (*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 **90 calendar days** of the date 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 Managed Care Organization (MCO), the denial of the enrollee's request to exercise the enrollee's right under 438.52(b)(2)(ii), and to obtain services outside the network. (*42 CFR 438.400(b)(6))*
- Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibility. (*42 CFR 438.400(b)(7))*

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

Advance Notice of Adverse Benefit Determination: 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 calendar days prior** to the proposed date the Adverse Benefit Determination takes 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. (*42 CFR 438.400(b)*).

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

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*)

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

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)*

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))*

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

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*)

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).

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*.

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*.

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

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*

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.*

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 (431.200 – 431.246).*

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

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

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with the PIHPs, that the PIHP has a Grievance and Appeal System in place for the enrollees that complies with *Subpart F of Part 438*.

The Grievance and Appeal System must provide enrollees:

- An Appeal process (one level only) enables enrollees the right to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints.
- 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.
- 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.

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

IV. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy. (*42 CFR 438.416(a))*

A PIHPs record of each Appeal and/or Grievance must contain, at a minimum *(42 CFR 438.16(b)):*

A. A general description of the reason for the Appeal or Grievance.

B. The date received.

C. The date of each review, or if applicable, the review meeting.

D. The resolution at each level of the Appeal or Grievance, if applicable.

E. The date of the resolution at each level, if applicable.

F. Name of the covered enrollee for whom the Appeal or Grievance was filed.

PIHPs must maintain such records. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. (*42 CFR 438.16(c))*

V. NOTICE OF ADVERSE BENEFIT DETERMINATION

The PIHP is required to provide timely and adequate notice of any Adverse Benefit Determination. (*42 CFR 438.404(a))*

A. Content and Format: The notice of Adverse Benefit Determination must meet the following requirements:

1. The enrollee notice must be in writing and must meet the requirements of *42 CFR 438.10* (i.e., "…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).

2. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

3. Description of Adverse Benefit Determination the PIHP has been made or intends to make. (*42 CFR 438.404(b)(1))*

4. The reason(s) for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. *(42 CFR 438.404(b)(2))*

5. Notification of the enrollee's right to request an appeal of the PIHPs adverse benefit determination, including information on exhausting the PIHPs one level of appeal, and the right to request a State Fair Hearing thereafter. (*42 CFR 438.404(b)(3))*

6. Description of the circumstances under which an Appeal can be expedited, and how to request an expedited Appeal.

7. Notification of the enrollee's right to have benefits continue pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination"). **(***42 CFR 438.404(b)(6))*

8. Description of the procedures that the enrollee is required to follow to exercise any of these rights. (*42 CFR 438.404(b)(4))*

9. An explanation that the enrollee may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman. (*45 CFR 155.505(e))*

B. Timing of Notice *(42 CFR 438.404(c))*:

1. Adequate Notice of Adverse Benefit Determination:

   a. For a denial of payment for services requested but not currently provided, notice must be provided to the enrollee at the time of the action affecting the claim. (*42 CFR 438.404(c)(2))*

   b. For a Service Authorization decision that denies or limits services, notice must be provided to the enrollee within **14 calendar 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. (*42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3) and (6))*

c. For Service Authorization Decisions not reached within **14 calendar days** for standard request, or **72 hours** for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. (*42 CFR 438.404(c)(5))*

NOTE: the PIHP may be able to extend the standard (**14 calendar days**) or expedited (**72 hour**) Service Authorization timeframes for up to **an additional 14 calendar days** if either the enrollee requests the extension, or if the PIHP can show that there is a need for additional information and the extension is in the enrollee's best interest (*42 CFR 438.210(d)(1)(ii)).* If the PIHP extends the time **NOT** at the request of the enrollee, the PIHP must: (i.) make reasonable efforts to give the enrollee prompt oral notice of the delay; (ii.) within **2 calendar days**, provide the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he/she disagrees with that decision; and (iii.) issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (*42 CFR 438.404(c)*(4*); 42 CFR 438.408(c)(2); 438.410(c)(2))*

2. Advance Notice of Adverse Benefit Determination:

a. Required for reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services. Must be provided to the enrollee at least **10 calendar days** prior to the proposed effective date. (*42 CFR 438.404(c)(1); 42 CFR 431.211)*

b. Exceptions from advance notice:

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 PIHP has verified information confirming the death of the enrollee. *(42 CFR 431.213(a))*

ii. The PIHP receives a clear and written statement signed by the enrollee that he/she no longer wishes services per 42 CFR 431.213(b)(1); or that gives information that requires termination or reduction of services, and indicates the enrollee understands this must be the result of supplying that information. *(42 CFR 431.213(b)(2))*

iii. The enrollee has been admitted to an institution where he/she is ineligible under the plan for further services. (*42 CFR 431.213(c))*

iv. The enrollee's whereabouts are unknown, and the post office returns agency mail directed to the enrollee indicating no forwarding address. *(42 CFR 431.213(d))*

v. The PIHP establishes that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth. *(42 CFR 431.213(e))*

vi. A change in the level of medical care is prescribed by the enrollee's physician. *(42 CFR 431.213(f))*

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the SSA. *(42 CFR 431.213(g))*

viii. The date of action will occur in less than **10 calendar days**. *(42 CFR 431.213(h))*

ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the enrollee (in this case, the PIHP may shorten the period of advance notice to **5 calendar days** before the date of action). (*42 CFR 431.214*)

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The enrollee must be provided written notice. (*42 CFR 438.404(a); 42 CFR 438.210(c))*

2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice to the provider does NOT need to be in writing. (*42 CFR 438.210(c))*

3. If the utilization review function is not performed within an identified organization, program, or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the PCP process still constitutes an adverse benefit determination and requires a written notice of action. *(42 CFR 438.210(e))*

VI. MEDICAID BENEFITS AND SERVICES CONTINUATION OR REINSTATEMENT

A. Continuation of benefits:

The PIHP must continue the enrollee's benefits if all the following occur (*42 CFR 438.420(b)*):

1. The enrollee files the request for an appeal timely within **60 calendar days** from the date on the Adverse Benefit Determination Notice. (*42 CFR 438.420(b)(1); 42 CFR 438.402(c)(ii))*

2. 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) "Timely files*");

3. The Appeal involves the termination, suspension, or reduction of previously authorized services (*42 CFR 438.420(b)(2));*

4. The services were ordered by an authorized provider (*42 CFR 438.420(b)(3)*);

5. The period covered by the original authorization request has not expired (*42 CFR 438.420(b)(4)**);*** and

B. 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:

1. The enrollee withdraws the Appeal or request for State Fair Hearing. *(42 CFR 438.420(c)(1))*

2. The enrollee fails to request a State Fair Hearing and continuation of benefits within **10 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))*

3. The State Fair Hearing office issues a decision adverse to the enrollee. *(42 CFR 438.420(c)(3))*

C. 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))*

D. 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))*

E. 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))*

F. 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))*

VII. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, 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 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:

1. The enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. (*42 CFR 438.402(c)(2)(ii))*

2. The Appeal can be requested orally or in writing. (*42 CFR 438.402(c)(3)(ii))*

   NOTE: Oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as appeals (to establish the earliest possible filing date for the Appeal). (*42 CFR 438.406(b)(3))*

3. 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))*

B. PIHP Responsibilities when the Enrollee Requests Appeals:

1. 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))*

2. The PIHP must acknowledge receipt of an expedited Appeal within 72 hours of receipt. 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))*

3. The PIHP must maintain a record of appeals for review by the State as part of its quality strategy. *(42 CFR 438.416(a))*

4. The PIHP must ensure that the individual(s) who make the decisions on appeals are individuals:

a. 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)*);

b. 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

c. 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))*

5. 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))*

6. 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))*

7. 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*))

8. 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)).*

C. Appeal Resolution Timing and Notice Requirements:

1. 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. (*42 CFR 438.408(b)(2)*

2. Expedited Appeal Resolution (timing):

a. 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))*

b. 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 **30 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))*

3. 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))*

4. 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. Attached to this agreement are required notice templates for Appeals and Grievances. They are titled, "Exhibit A - Notice of Adverse Benefit Determination", "Exhibit B - Notice of Receipt of Grievance", "Exhibit C - Notice of Grievance Resolution, "Exhibit D – Notice of Receipt of Appeal", "Exhibit E, Notice of Appeal Approval," and "Exhibit F – Notice of Appeal Denial.". These templates incorporate the information needed to meet the requirement of Appeals and Grievances recordkeeping in *42 CFR 438.416*, and section IV. Recordkeeping Requirements of this technical requirement.

b. 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.

5. 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 wholly 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))*

VIII. GRIEVANCE PROCESS

A. 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")*

B. Generally:

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

2. 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))*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. 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))*

2. Acknowledge receipt of the Grievance **within five (5) business days**. (*42 CFR 438.406(b)(1))*

3. Maintain a record of Grievances for review by the State as part of its quality strategy. (42 CFR 438.416(a))

4. Ensure that the individual(s) who make the decisions on the Grievance are individuals:

   a. Who were neither involved in any previous level review or decision-making, nor a subordinate of any such individual. (*42 CFR 438.406(b)(2)(i))*

   b. 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))

   c. Who consider 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))

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution:

   Provide the enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance. (42 CFR 438.408(b)(1))

2. Extension of Timeframes:

   The PIHP may extend the Grievance 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 that there is a need for additional information and how the delay is in the enrollee's interest. (*42 CFR 438.408(c))*

   a. If the PIHP 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. (*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))*

3. Format and Content of Notice of Grievance Resolution:

   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. The notice of Grievance resolution must include:

      i. The results of the Grievance process.

      ii. The date the Grievance process was concluded.

IX. STATE FAIR HEARING PROCESS

A. 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:

1. After receiving notice that the PIHP is upholding an Adverse Benefit Determination after Appeal. *(42 CFR 438.408(f)(1));*

2. 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).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions are met:
   1. 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)*)
   2. The review must be independent of both the State and the PIHP. (*42 CFR 438.408(f)(1)(ii)(B)*)
   3. The review must be offered without any cost to the enrollee. (*42 CFR 438.408(f)(1)(ii)(C)*)
   4. 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)*)

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

D. 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)*)

E. 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.

F. 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)*)

G. 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)*)

H. 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:

http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

OR

Department of Licensing and Regulatory Affairs
Michigan Office of Administrative Hearings and Rules
State Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

Exhibit A

LETTER OF ADVERSE BENEFIT DETERMINATION

Adverse Benefit Determination is a decision made by a health plan that:

- denies a request for a service(s);
- denies payment;
- reduces or stops a benefit; or
- does not provide services in time.

Appeal is a request you can make to ask that a decision that you do not agree with is looked at again.

Important: This letter explains your Appeal rights. Read this letter carefully. If you need help with this letter or disagree with the decision that was made, you can call one of the numbers listed on the last page under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

This is to tell you about our decision:

This decision is based on the following:

There is a law [42 CFR §440.230(d)] that allows us to place appropriate limits on service requests based on the reason for the medical need.

You can share a copy of this letter with your provider so you and your provider can discuss next steps. If your provider asked for these services to be provided to you, we have sent a copy of this letter to your provider.

If you do not agree with our decision, you have the right to an Appeal.
You must ask the [CMHSP/PIHP] for an Appeal within **60 days** of the date of this letter. You can name a relative, friend, attorney, provider, or another person to speak for you with your permission. If you already have a person approved to make legal health care decisions for you, you do not have to do anything else. The Appeal can be requested either verbally or in writing.

There are two (2) types of Appeals:

Standard Appeal:

You will be provided with a written decision on a Standard Appeal within **30 days** after your Appeal is received. Our decision might take longer than 30 days if you ask for more time, or if we need more information about your case. We will tell you if we are taking extra time and we will explain why more time is needed.

Fast Appeal:

You will be provided with a decision on a Fast Appeal within **72 hours** after your Appeal is received. You or your provider can ask for a Fast Appeal if you or your provider believe your health could be seriously harmed by waiting up to 30 days for a decision. [CMHSP/PIHP] will decide if your request is considered a Fast Appeal. If you are not provided a Fast Appeal, you will be called as soon as possible to tell you and then you will be given a decision within **30 days**. To ask for a Fast Appeal, you must call: **[telephone number] [TTY telephone number]** right away.

Next steps if you want to file an appeal:

When asking for an Appeal, you must tell us the following:

- Your Name.
- Your Address.
- Your Member Number.
- Your Reason for the Appeal.
- Whether you want a Standard or Fast Appeal.
- If you want someone to speak for you. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.
- Any proof you want us to review, such as medical records, letters from your providers, or other information that explains why you need the item or service. [Note: There is a limited time available if you are asking for a Fast Appeal.]
- If your services were stopped or reduced, if you want your services to continue.

If you would like to continue the services that you are currently receiving, you must follow the below:

If you ask for an Appeal within **10 days** of this letter, in some cases, you may continue to receive your services while your Appeal is being looked at. Your request to continue services can be sent at the same time with your Appeal request.

If your services are continued during your Appeal, you can keep getting the service(s) until one of the following happens: 1) you cancel the Appeal; or 2) all individuals that receive and review your Appeal decide to say “no” to your request; or 3) the original approval request for your services has ended. You may be asked to pay for some of the services you received during the Appeal process if the Appeal is not approved. This is not always the case, but if you do need to pay, you will be notified of the amount.

Access to Documents:

You and/or your approved individual are allowed access to and a free copy of all documents that relate to your appeal any time before or during the appeal. You can ask for these documents either by requesting in writing or by calling Customer Services at the number below or if you have any questions or concerns about this decision.

What happens next:

- If you ask for an Appeal, [CMHSP/PIHP] will review information about the Appeal request and send you a letter with the decision. If [CMHSP/PIHP] does not support your Appeal, the letter will explain why [CMHSP/PIHP] did not approve your request.

- You can ask for a Medicaid State Fair Hearing. The State Fair Hearing process can only be used after [CMHSP/PIHP] does not approve your Appeal. The letter that will be sent to you will give you more information about the State Fair Hearings process and how to file the request.

- If [CMHSP/PIHP] approves your Appeal, you will receive a letter that explains the steps you and [CMHSP/PIHP] will follow to approve the services that are now allowed.

- If you do not receive a letter or decision about your Appeal within **30 days** of the Standard Appeal **or 72 hours** of your Fast Appeal, your appeal is considered finished, and you may file a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR). Please call us to get this information.

Get help and more information:

- If you need help or more information about our decision and the Appeals process, call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].

- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Service at one of the numbers listed above under “Get help and more information.”

Exhibit B

YOUR LETTER OF GRIEVANCE WAS RECEIVED

Important: Read this letter carefully. If you need help, you can call one of the numbers listed under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

YOU FILED A GRIEVANCE

Your Grievance was received on [date received], about [subject of grievance]. What you say happened to you matters to us. Thank you for letting us know.

WHAT THIS MEANS

Your Grievance will be looked at, and a letter will be mailed to you within 90 days once the review is completed; telling you what was found and what (if any) steps will be taken or have been taken.

We may contact you for more information or if we have questions. If you have any questions or more information to provide to us, please call {telephone number}.

If you want someone else to speak for you:

At any time during the Grievance process, you can name a relative, friend, attorney, provider, or another person to speak for you. If you want someone to speak for you, you must tell us that in writing. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.

If you already have someone that is approved to make legal health care decisions for you, you do not have to do anything else.

Get help and more information:

- If you need help or more information call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities, so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get Help and More Information.”

Exhibit C

LETTER OF GRIEVANCE DECISION

Important: Read this letter carefully.

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

You Filed a Grievance

Your grievance was about [enter reason]. Thank you again for taking the time to bring this to our attention.

We have reviewed your grievance, which was [enter # of days] from when your grievance was received.

Based on our review, the following action has occurred: [enter decision]

This matter is considered closed at this time.

Get help and more information:

- If you need help or more information about our action and the Grievance process, call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities, so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get help and more information.”

Exhibit D

YOUR LETTER OF APPEAL WAS RECEIVED

Important: Read this letter carefully. If you need help, you can call one of the numbers listed below.

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

You Filed an Appeal

Your Appeal was received on [date received], about [subject].

WHAT THIS MEANS

Your Appeal will be looked at, and a letter will be mailed to you by [**30 calendar days, or within 72 hours if a fast appeal has been approved**] telling you what our decision is and why we made that decision.

We may contact you for more information or if we have questions. If you have any questions or more information to provide to us, please call: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].

If you want someone else to speak for you:

At any time during the Appeal process, you can name a relative, friend, attorney, provider, or another person to speak for you. If you want someone to speak for you, you must tell us that in writing. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.

If you already have someone that is approved to make legal health care decisions for you, you do not have to do anything else.

Access to Documents

You and/or your approved individual are allowed access to and a free copy of all documents that relate to your current appeal. [PIHP/CMHSP] will provide you with this information.

There is a law that does not allow [PIHP/CMHSP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[PIHP/CMHSP] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
  - Someone who speaks your language.
  - Information written in another language.

If you need these services, you can call Customer Services at {telephone number} [TTY telephone number].

Exhibit E

LETTER OF APPEAL APPROVAL

Important: This letter explains the results of your Appeal. Read this letter carefully. If you need help, you can call one of the numbers listed below under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

This Letter is in response to the Appeal request that was received on [date appeal received].

Your appeal was approved.
Your appeal was fully considered. This is to let you know that we approved your appeal for the service(s)/item(s) listed below:

What this means:
Because your Appeal was approved, you may receive the following service(s) as of:

If you do not receive the services, or if the services are mistakenly stopped or reduced, contact us **immediately** using the following information:

[CMHSP/PIHP Name]
[Name of Appeals/Grievance Department]
[Mailing Address for Appeals/Grievance Department]

Phone: [Telephone Number] TTY: [TTY Telephone Number]
Fax: [Fax Number]

Get help and more information:

- If you need help or additional information about the decision, call Customer Services at: {telephone number}; TTY: [TTY telephone number] {hours of operation}. You can also visit our website at [PIHP/CMHSP website].

- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [PIHP/CMHSP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP/Name] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
    - Someone who speaks your language.
    - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get Help and More Information.”

Exhibit F

LETTER OF APPEAL DENIAL

Important: This letter explains the reason for the decision of your Appeal and your other Appeal rights. Read this letter carefully. If you need help, you can call one of the numbers listed under "Get help and more information."

Mailing Date: **Member ID:**

Name: **Beneficiary ID:**

This Letter is in response to the Appeal request that we received on [date received]

Your Appeal was not approved:
Your Appeal was fully considered. This is to let you know that we did not approve your Appeal for the service(s)/item(s) listed below:

Why did we not approve [or partially approve] your appeal?
Your Appeal was not approved for the service(s)/item(s) listed above because:

You can share a copy of this letter with your provider so you and your provider can discuss next steps. If your provider asked for these services to be provided to you, we have sent a copy of this letter to your provider.

If you have any questions or concerns about this decision, please call Customer Services at the contact information provided below.

If you do not agree with the decision, you have the right to additional appeal options.

You have the right to ask for a State Fair Hearing (a different appeal). The State Fair Hearing is reviewed by another organization that is not a part of [enter PIHP/CMHSP]. You can file a State Fair Hearing yourself or Customer Service is available to help you complete the paperwork to file. Below is the information on how to request a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR).

How to ask for a State Fair Hearing with MOAHR:

To ask for a State Fair Hearing, you must follow the directions on the paper in this envelope that says "**Request for State Fair Hearing"** form. You must ask for a State Fair Hearing within **120 days** from the date listed on this letter for a hearing to be granted. If you need another copy of the form, you can ask for one by calling [CMHSP/PIHP Name] Customer Services at {[telephone number}, TTY: [TTY telephone number] or the MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

What happens next:

- The MOAHR will schedule a State Fair Hearing. You will get a written "Letter of Hearing" telling you the date and time the hearing is scheduled.
- Most hearings are held by telephone; however, you can ask to have a hearing in person if you make this request. During the hearing, you will be asked to tell a Judge why you disagree with your Appeal not being approved (or partially approved).
- You can ask a friend, relative, provider, or lawyer to help you. You must include this person on the State Fair Hearing request form. You have the right to send information to the judge to review as part of the hearing process.
- After the hearing, you will get a written "Decision and Order" letter within **90 days** from when you asked for the hearing. This letter will include the decision by the Judge and, if not decided in your favor, explain any Appeal rights.

If the timeframe for review would seriously harm your life or health, you may be able to get a fast State Fair Hearing. Your request must be in writing, and you must say that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MOAHR (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MOAHR must give you an answer within **72 hours**. However, if MOAHR needs to gather more information that may help you, MOAHR can increase the time by up to **14 days**.

If you have any questions about the State Fair Hearing process, including the fast State Fair Hearing process, you can call MOAHR at 1-877-833-0870.

Ongoing Benefits:

If coverage for a service was previously approved but then the service was changed or stopped before the approval ended, you can continue your benefits during this the State Fair Hearing in some cases.

Your service(s) can continue if you qualified for ongoing benefits during your Appeal with [PIHP/CMHSP] and you ask for a State Fair Hearing from MOAHR within **10 days** from the date of this letter. MOAHR must receive your State Fair Hearing by [insert 10 calendar day date from this letter]. You should let [CMHSP/PIHP Name] know you have requested a State Fair Hearing within 10 days, and you are asking for your service(s) to continue.

If your benefits are continued during your State Fair Hearing, you can keep getting the service(s) until one of the following happens: 1) you cancel the State Fair Hearing; or 2) the State Fair Hearing is held, and the Judge says “no” to your State Fair Hearing request, or 3) the original approval request for your services has expired.

You may be asked to pay for some of the services you received during the Appeal and/or the State Hearing process if the State Hearing outcome is not approved. This is not always the case, but if you do need to pay, you will be told the amount.

Access to Documents

You and/or your approved individual are allowed access to and a free copy of all documents relevant to the State Fair Hearing any time before or during the State Fair Hearing process. You can make a request in writing or by contacting Customer Services at the number below.

Get help and more information:

- If you need help or additional information about our decision, call Customer Services at: {telephone number} TTY: [TTY telephone number], [hours of operation]. You can also visit our website at [Health Plan Website URL].

- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet-based phone service).

There is a law that does not allow [CMHSP/PIHP] to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

[CMHSP/PIHP] provides help to people with different abilities so they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
  - Someone who speaks your language.
  - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under “Get Help and More Information.”