Policy & Procedure

POLICY/PROCEDURE TITLE: Grievance and Appeals of Supports/Services **POLICY/PROCEDURE #:** 1103 **Section:** Customer Services **Developed and maintained by:** Customer Services **Scope:** ☒ OnPoint Staff ☐ MH/IDD, ☐ Housing, ☐ SUD, ☐ Integrated Health, ☒ OnPoint Contract Providers ☐ Other _____	**Approved By:** _____ (Chief Executive Officer) **Approved By:** _____ (Medical Director; *as applicable*)

DATES	
First Effective	06/1999
Revised	04/2025
Supersedes	07/2022

PURPOSE

To ensure all individuals receiving OnPoint services have a right to a fair and efficient process for grievances and disputes related to the denial, reduction, suspension or termination of services and supports. To also outline a process by which appeals and grievances will be received, explored, resolved, and reported to the region. This policy/procedure in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Mental Health Code and Affiliate policies relative to the filing of Recipient Rights Complaints.

POLICY

OnPoint will provide for a fair and efficient process of handling Medicaid and non-Medicaid grievances, and for resolving reduction, suspension, termination or denial of service(s).

DEFINITIONS

A) Adverse Benefit Determination A decision that adversely impacts a Medicaid beneficiary's claim for services due to:
   1) Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.
   2) Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.
   3) Denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service.
   4) Failure to make an authorization decision and provide notice about the decision within standard time frames.
   5) Failure to provide Medicaid or non-Medicaid services within standard time frame.
   6) In regard to Medicaid covered services, failure of the PIHP to act within the time frames required for disposition of grievances and appeals.
   7) For a resident of a rural area with only one PIHP, the denial of a Medicaid enrollee's request to exercise their right to obtain services outside the network.

B) Adequate notice

Written statement advising the individual of a decision to deny or limit authorization of Medicaid services requested. Notice to individual on the same date each action takes effect or at the time of the signing of the individual plan of services/supports.

C) Advance notice
Written statement advising the individual of a decision to reduce, suspend, or terminate Medicaid services currently provided. Notice to be provided/mailed at least ten (10) calendar days prior to the proposed date the action is to take effect.

D) Appeal
A review by the PIHP of an Adverse Benefit Determination. B3 Services
A set of MDHHS and CMS approved services which may be provided under the authority of Section 1915(b)(3) of the Social Security Act. The intent of B3 Services (formerly known as alternative services) is to fund medically necessary supports and services that promote community inclusion and participation, independence and/or productivity when identified in the individual plan of service as one or more of goals developed during the person-centered planning process.

E) Beneficiary
An individual who is eligible or and enrolled in the Medicaid program in Michigan.

F) Grievance
An expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, other than an adverse benefit determination as defined above. 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 member's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP to make an authorization decision.

G) Inquiry
A contact made to CMHSP/PIHP Customer Services by a consumer, guardian, family member or friend, provider, or anyone in the community seeking information and/or assistance. Inquiries can include, but are not limited to, requests for information about benefits, services, providers, transportation, and available community resources.

H) Medicaid covered service
A Medicaid State Plan, B3, Children's Waiver, Children's SED Waiver, or Habilitation Supports Waiver service as defined in the most recent version of Chapter III of the Michigan Department of Community Health, Medical Services Administration Bulletin.

I) Reasonable Person
A phrase frequently used in Tort and Criminal Law to denote a hypothetical person in society who exercises average care, skill, and judgment in conduct and who serves as a comparative standard for determining liability.

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

K) Resolution notice
A notice sent to the individual, guardian, parent of a minor child, or legal representative explaining the action taken to resolve their grievance, appeal, or dispute (also referred to as disposition letter).

L) State Fair Hearing

A state level review of beneficiaries' disagreements with CMHSP, or PIHP denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Health and Human Services perform the reviews.

PROCEDURE

I. Notice of Adverse Benefit Determination OnPoint must provide a beneficiary with a timely and adequate notice of an adverse benefit determination in writing that meet the language and alternative format needs of the member, meaning in a manner and format that may be easily understood, per limited English proficiency, language, and format standards, and that is readily accessible, meaning electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions, by such beneficiaries and potential beneficiaries when the CMHSP:

A. OnPoint will use the notice of adverse benefit determination template from the MDHHS/PIHP contract ensuring consistency across the region and compliance with 42 CFR 438.404(b). OnPoint will provide a notice of adverse benefit determination when OnPoint:
    a. Denies payment, in whole or in part, on a claim, ***at the time of any action affecting the claim*** (meaning on the same date the decision to deny payment is made).
    b. reduces or terminates service(s) in the IPOS due to a reduced need which must be determined through the person-centered planning process and based on medical necessity. If the individual served does not agree with the reduction of service(s) or termination, the CMHSP must provide notice ***at the time of review/signing of the IPOS*** via an Advance Notice of Adverse Benefit Determination as described in the Appeal and Grievance Resolution Process and Technical Requirements, which requires ***10 calendar days advance notice prior to the reduction, suspension, or termination of services.***
    c. denies a standard service authorization request or authorizes a service in an amount, duration, or scope that is less than requested in a standard service authorization request, ***within 14 calendar days after receiving the request for service.***
    d. denies an expedited service authorization request or authorizes a service in an amount, duration, or scope that is less than requested in an expedited service authorization request, ***within 72 hours after receiving the request for service.***
    e. terminates, suspends, or reduces previously authorized services, ***at least 10 calendar days before the date of termination, suspension, or reduction.***

B. The written notice must contain the following:
    1. The action taken or intended to be taken.
    2. The reason(s) for the action.
    3. The date of the intended action.
    4. If access to services or hospitalization is denied, the right to request a second opinion and an explanation of the process.
    5. The individual's right to file an appeal or local dispute.

6. In regard to Medicaid covered services, the individual's right to request a MDHHS Fair Hearing and the timeframes for doing so.
7. The procedures for exercising the resolution options.
8. The circumstances under which expedited resolution is available and how to request it.
9. In regard to Medicaid covered services, the individual's right to have benefits continue pending resolution of the appeal or MDHHS Fair Hearing decision, how to request that benefits be continued, and the circumstances under which the individual may be required to pay the costs of these services. The notice must specify that if the individual requests a MDHHS Fair Hearing prior to the date of action (i.e., suspension, reduction, or termination of a Medicaid covered service), in most circumstances OnPointmay not reduce, suspend, or terminate the services until a decision is rendered after the hearing.

C. Limited Exceptions: OnPoint may mail an adequate notice instead of an advance notice of action not later than the date of the action to terminate, suspend, or reduce previously authorized services IF:
   1. OnPoint has factual information confirming the death of the individual.
   2. OnPoint receives a clear written statement signed by the individual or their legal representative that:
      a. they no longer wishes services; or
      b. Gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying the information.
   3. The individual has been admitted to an institution where they is ineligible under Medicaid for further services.
   4. The individual's whereabouts are unknown and the post office returns the OnPoint's mail directed to them indicating no forwarding address.
   5. OnPoint establishes the fact that the individual has been accepted for Medicaid services by another Local jurisdiction, State, territory, or commonwealth.
   6. A change in the level of medical care is prescribed by the individual's physician.
   7. The date of the action will occur in less than ten (10) calendar days.
   8. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act.
   9. The notice of a transfer or discharge may be less than 10 calendar days if:
      a. The safety of individuals in the facility would be endangered under 42 CFR 438.213(c)(1)(i)(C);
      b. The health of individuals in the facility would be endangered, under 42 CFR 438.213((c)(1)(i)(D);
      c. The resident's health improves sufficiently to allow a more immediate transfer or discharge, under 42 CFR 438.213(c)(1)(i)(B);
      d. An immediate transfer or discharge is required by the resident's urgent medical needs, under 42 CFR 438.213(c)(1)(i)(A); or
      e. A resident has not resided in the facility for 30 days.
   10. The CMHSP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the member (in this case, the CMHSP may shorten the period of advance notice to 5 days before the date of action).

D. Provider's Right to Appeal.

1. A provider acting on behalf of a Medicaid eligible individual and with the individual's written consent may file an appeal to the PIHP. The provider may file a grievance or State Fair Hearing on behalf of the individual **only** if the State permits the provider to act as the individual's authorized representative in doing so.
2. The requesting provider, in addition to the individual, must be provided notice of any decision by the Affiliate to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider is not required to be in writing.
3. Punitive action may not be taken by the Affiliate against a provider who acts on the individual's behalf with the individual's written consent to do so.

E. Continuation of Benefits

1. OnPoint must continue the member's benefits if all of the following occur:
    a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).
    b. The appeal involves the termination, suspension, or reduction of previously authorized services.
    c. The services were ordered by an authorized provider.
    d. The period covered by the original authorization has not expired.
    e. The member timely files for continuation of benefits.
        1. Timely files means on or before the later of the following: within ten (10) calendar days of the PIHP sending the notice of ABD, or the intended effective date of the PIHP's proposed ABD
2. If, at the member's request, the PIHP continues or reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs:
    a. The member withdraws the appeal or request for State fair hearing.
    b. The member fails to request a State fair hearing and continuation of benefits within ten (10) calendar days after the PIHP sends the notice of an adverse resolution to the member's appeal.
    c. A State fair hearing office issues a hearing decision adverse to the member.
    d. The authorization expires or authorization service limits are met.
3. If the PIHP or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
4. If the PIHP or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PIHP must pay for those services.

F. OnPoint must provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

II. Second Opinions

A. Denial of hospitalization – Any or all of the following processes may be utilized:

1. Request for second opinion
   a. If a Pre-Admission Screening Unit or Children's Diagnostic and Treatment Service of the Affiliate denies hospitalization, the individual, their guardian, or their parent in the case of a minor child, may request a second opinion from the Chief Executive Officer of the Affiliate.
   b. The request for the second opinion shall be processed in compliance with Sections 409(4), 498e (4) and 498h (5) of the Code. If the conclusion of the second opinion is different from the conclusion of the Children's Diagnostic and Treatment Service or the Pre-Admission Screening Unit, the Chief Executive Officer, in conjunction with the Medical Director, shall make a decision based upon all clinical information available within one (1) business day.

B. Denial of access to services for individuals not receiving any OnPoint's services:

1. Request for second opinion
   a. If an initial applicant for public mental health services is denied such services, the applicant or their guardian, or the applicant's parent in the case of a minor must be informed of their right to request a second opinion. The request shall be processed in compliance with Section 705 of the Code and must be resolved within five (5) business days.

III. Appeal of Denial of Family Support Subsidy

A. Demand for CMHSP Hearing and Appeal

1. Pursuant to Section 159(3) of the Code, if an application for a family support subsidy is denied or a family support subsidy is terminated by a Community Mental Health Services Program (CMHSP), the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the CMHSP. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, and being Sections 24.271 to 24.287 of the Michigan Compiled Laws.
2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the CMHSP. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeal hearing, in lieu of a standardized form.)
3. A CMHSP shall review an application, promptly approve or deny the application, and provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, the CMHSP shall identify the insufficiency. (Rule R330.1641 Application review)
4. If an application is denied or the subsidy is terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the CMHSP within two (2) months of the notice of the denial or termination (R330.1643 Appeal).
5. If the MDHHS representative, using a "reasonable person" standard, believes that the denial or termination of the subsidy will pose an immediate and adverse impact upon the individual's health and safety, the issue is to be referred within one (1) business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDHHS/CMHSP contract.

Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for DCH Level Dispute Resolution
Lewis Cass Building – 6th Floor
Lansing, MI 48913

IV. Medicaid Fair Hearings

A. The member may request a State fair hearing only after receiving notice that the PIHP is upholding the ABD related to the appeal.
B. The member is given one hundred twenty (120) calendar days from the date of the PIHP's notice of appeal resolution to request a State fair hearing.
C. The PIHP must include as parties to the appeal and State fair hearing:

a. The member and his or her representative.
b. The legal representative of a deceased member's estate.
c. For State fair hearings, the PIHP.

V. MDHHS Alternative Dispute Resolution Process

A. Within ten (10) days of receipt of the written decision on the Local Dispute (appeal or grievance), the individual, their guardian, or parent of a minor individual may file a request for a MDHHS level Dispute Resolution to:

Michigan Department of Health and Human Services
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for MDHHS Level Dispute Resolution
Lewis Cass Building – 6th Floor
Lansing, MI 48913

B. If the MDHHS representative, using a "reasonable person" standard, believes the denial, suspension, termination, or reduction of the services and/or supports will pose an immediate and adverse impact upon the individual's health and safety, the issue is to be referred within one (1) business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDHHS/PIHP contract.

C. In all other cases, MDHHS shall complete its review of the dispute within fifteen (15) business days of receipt. Written notice of the resolution shall be submitted to the individual, their guardian, or parent of a minor beneficiary.

Grievance and appeal records must be retained for ten (10) years from the final date of the contract period of from the date of completion of any audit, whichever is later.

VI. Local Appeals Resolution Requirements and Process

A. Requirements for Appeals.
1. The process for appeals must:

a. Provide that oral requests for appeal of an action are treated as appeals (to establish the earliest possible filing date for the appeal).
b. Give the individual reasonable assistance in completing forms and taking other steps to complete the appeals process. This assistance includes, but is not limited to, Interpreter Services, and Affiliate's toll-free numbers that have TTY/TTD and interpreter capability. These numbers are to be found in the Lakeshore Region Guide to Services handbook, agency brochures, and on the Notice of Adverse Benefit Determination forms. Also refer to ONPOINT Policy/Procedure #105 Accessibility and Accommodations Services.
c. Provide the individual a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The PIHP must inform the individual of the limited time available for this in the case of expedited resolution.)
d. Provide the individual and their representative the opportunity, before and during the appeals process, to examine the individual's case file, including medical records, and any other documents considered during the appeal process. Also refer to ONPOINT Policy/Procedure #907 Confidentiality and Disclosure of Consumer Information.
e. Include, as parties to the appeal:
   - The individual and their representative; or
   - The legal representative of a deceased individual's estate.
f. If the individual, or representative, requests a local appeal not more than ten (10) calendar days from the date of the notice, the Affiliate must reinstate the Medicaid services until disposition of the hearing.

B. Appeal Process

1. Within sixty (60) calendar days of receipt of Notice of Adverse Benefit Determination date, the individual or their legal representative, or, with written consent, the provider on the individual's behalf, may file an appeal either orally or in writing with the PIHP's Customer Service department which shall then:
   a. Log receipt of the appeal for reporting purposes.
   b. Acknowledge receipt of the appeal within 5 business days of receipt for standard appeals, and within 72 hours of receipt for an expedited appeal ; and for a Medicaid beneficiary disputing an action that impacts a Medicaid covered service, advise the individual, guardian, or in the case of a minor, the parent, that he/she may file a request for a State Fair Hearing if disagree with the appeal resolution. Information regarding how to file a State Fair Hearing will be included in the appeal resolution notice along with an offer of assistance in filing the request and an explanation of time frames and circumstances under which Medicaid services will be continued pending the hearing decision.
   c. 9.33 The PIHP must ensure that the individuals who made decisions on appeals are individuals:
      a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
      b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:
      i. An appeal of a denial that is based on lack of medical necessity.
      ii. An appeal that involves clinical issues.

c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.

d. Facilitate the review of the appeal and send a written decision within thirty (30) calendar days from receipt of the appeal.

e. Assure an expedited review of an appeal when the PIHP determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) the standard thirty (30) day time frame would seriously jeopardize the physical or mental health or life of the individual or ability to attain, maintain, or regain maximum function. Such a review shall be completed within 72 hours of receipt of the appeal.

f. The PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. Assure the content of the resolution notice and time frame for submission to the individual and their legal representative complies with the Resolution Notice requirements.

C. Resolution Notice

1. Written notice of the appeal resolution be written in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10 and must include:
   a. The results of the resolution process and the date it was completed.
   b. For appeals not resolved wholly in favor of the Medicaid beneficiary disputing action taken that impacts Medicaid covered services:
      - The right to request a State Fair Hearing, and how to do so, including an offer of assistance;
      - The right to request to receive services while the hearing is pending, if requested within ten (10) calendar days of the Affiliate mailing the notice of resolution/ disposition, how to make the request, including an offer of assistance;
      - The individual may be held liable for the cost of those services if the hearing decision upholds the PIHP and/or Affiliate's action.
   c. For appeals not resolved wholly in favor of the individual who is disputing action taken that impacts non-Medicaid covered services:
      - The right to seek MDHHS alternative dispute resolution, how to do so, and an offer of assistance.
   d. For appeals resolved to the satisfaction of the individual or their legal representative, an explanation of, and an offer of assistance in the process for withdrawing any request filed for a State Fair Hearing.

D. Timing of Resolution Notice

1. Written notice of the appeal resolution must be submitted to the individual and their legal representative within thirty (30) calendar days following receipt of the appeal.
2. For notice of an expedited appeal, the PIHP and/ or Affiliate must make reasonable efforts to provide oral notice as soon as possible followed by written notice within 72 hours following the receipt of the request for expedited resolution of the appeal.
3. The PIHP may extend the notice of disposition time frame by up to fourteen (14) calendar days if the individual 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 individual's

interest. If the PIHP extends the standard or expedited appeal resolution timeframes not at the request of the member, it must complete all of the following:
a. Make reasonable efforts to give the member prompt oral notice of the delay.
b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

4. If the PIHP denies a request for expedited resolution of an appeal, it must:
   - Transfer the appeal to the time frame for standard resolution or no longer than thirty (30) days from the date the Affiliate receives the appeal;
   - Make reasonable efforts to give the individual prompt oral notice of the denial;
   - Give the individual follow-up written notice within two (2) calendar days.

5. In the case that the PIHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process. The member may initiate a State fair hearing.

E. PIHP must maintain appeals records must be accurately maintained in a manner accessible to the PHIP, State and available upon request to CMS, and contain, at a minimum, all of the following information:
a. A general description of the reason for the appeal.
b. The date received.
c. The date of each review or, if applicable, review meeting.
d. Resolution at each level of the appeal, if applicable.
e. Date of resolution at each level, if applicable.
f. Name of the member for whom the appeal was filed.

X. Grievance Process

A. The individual, guardian, parent of a minor child, or their legal representative may file a grievance at any time regarding dissatisfaction with any aspect of service provision other than an adverse action as defined in this requirement or an allegation of individual rights violation.
   i) The individual must be given reasonable assistance in completing forms for filing a grievance.
   ii) The grievance shall be filed with the Customer Services department.
   iii) The grievance may be filed either orally or in writing
   iv) With the written consent of the individual, a provider or an authorized representative may file a grievance on behalf of the individual at any time.

B. The Customer Services Department shall then:
   1. Log receipt of the verbal or written grievance for reporting purposes.
   2. Refer grievances which contain alleged or suspected violations of Recipient Rights to the Office of Recipient Rights. Acknowledge to the individual the receipt of the grievance by mailing an acknowledgement letter within five (5) business days.
   3. Submit the written grievance to the appropriate staff including an administrator with the authority to require corrective action. Further, no staff members making decisions on the grievance shall have been involved in the original determination.
   4. OnPoint must ensure that individuals who make decisions on grievances are:

a. Individuals who are not involved in any previous level of review or decision making, nor a subordinate of any such individual.
b. Individuals who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:
    i. A grievance regarding denial of expedited resolution of an appeal
    ii. A grievance that involves clinical issues.

5. Resolve each grievance, and provide written notice of resolution to affected parties, as expeditiously as the member's health condition requires, within ninety (90) calendar days from the day OnPoint Customer Services receives the grievance.
   a. If a provider, after obtaining written consent from the member, filed a grievance on behalf of a member, OnPoint Customer Services will provide written notes of resolution to the filing provider.
   b. OnPoint Customer Services may extend the timeframe for resolving grievances by up to 14 calendar days if:
      i. The member requests the extension or
      ii. OnPoint Customer Services shows there is need for additional information and how the delay is in the member's interest.
      iii. If OnPoint Customer Services extends the grievance resolution timeframe not at the request of the member, it must complete the following:
         (a) Make reasonable efforts to give the member prompt oral notice of the delay
         (b) Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision.
6. The resolution notice will include, but not be limited to:
   a. The results of the grievance process
   b. The date the grievance process was concluded
   c. The beneficiary's right to request a fair hearing if the notice of resolution is more than 90 days from the date of the request for a grievance, and
   d. How to access the fair hearing process

7. OnPoint Customer Services will maintain accurate grievance records in a manner accessible to the LRE, State, and CMS upon request. These records will contain, at a minimum, the following information:
a. A general description of the reason for the grievance
b. The date received
c. The date of each review, or if applicable, review meeting.
d. Resolution at each level of the grievance, if applicable.
e. Date of resolution at each level, if applicable.
f. Name of the member for whom the grievance was filed.

REFERENCES

1. MDHHS Grievance and Appeal Technical Requirements
2. 42 CFR 438.10
3. 42 CFR 431.200

4. 42 CFR 438.400
5. 42 CFR 438.404(c)(1)
6. 42 CFR 431.211
7. 42 CFR 431
8. MI Mental Health Code
9. MDHHS Medicaid Specialty Supports and Services Contract
10. CMHSP/PIHP Service Contract