Title:	3.6.17, Appeals and Grievances		
Subject:	RECIPIENT RIGHTS		
Section:	Clinical		
Policy: □ **Procedure:** X	**Issued by:** Director of Quality, Customer Service, and Recipient Rights	**Effective Date:** 01/17/99	**Applies to:** **X All CMHA-CEI staff** **X Contract Providers**
Page: 1 of 9	**Approved by:** N/A	**Review Date:** 04/20/17	**X Other:** Consumers

I. Purpose:

To provide a fair and efficient process for resolving concerns, complaints, disputes, grievances and appeals from recipients of service or applicants for service, related to suspension, termination, reduction or denial of services and supports managed and/or delivered by Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI).

II. Procedures:

A. Underlying values and principles of CMHA-CEI's grievance and appeal process:

1. Timely;
2. Fair to all parties;
3. Administratively simple;
4. Objective and credible;
5. Accessible and understandable to consumers;
6. Cost and resource efficient; and
7. Subject to quality review.

B. Characteristics of complaint resolution systems:

1. CMHA-CEI's resolution system will follow the requirements set forth in the Grievance and Appeal Technical Requirement Guidelines from the Michigan Department of Health and Human Services.

2. All processes will promote the resolution of concerns and improvement of the quality of care.

3. Applicants/recipients may access more than one process simultaneously or sequentially.

4. Complaints should be resolved at the level closest to service delivery when possible but information regarding access to all complaint resolution processes will be provided to the applicant/recipient of services. If unable to resolve the complaint at the unit, department or program level, the administrator will assist the individual in filing appropriate forms to access appeals/grievances processes as defined in this procedure.

5. Written notification of complaint resolution will be provided to the individual with information about additional appeals/grievance processes.

6. The CMHA-CEI Customer Service department will be the contact point for the appeals/grievance system.

C. When to share appeals processes information

1. **At the initial face to face contact** with an applicant/legal representative, a copy of the Member Handbook will be provided.
2. **At the annual intake** each consumer shall be offered a new copy of the Member Handbook
3. **When requested by a consumer/authorized representative.** Questions about the appeal and grievance process can be directed to CMHA-CEI's Customer Service department.
4. **When a decision is made to admit a recipient to a hospital, crisis residential unit or a partial hospitalization program**, notice is provided to that recipient/legal representative that he/she will be discharged when he/she no longer meets continuing stay criteria. The notice will identify the appeal processes that are available if the recipient disagrees with the decision. The notice may be presented in person or mailed to individual's home address on the day of admission. Appeal processes include:

    a. Local grievance and appeal process
    b. DHHS Fair Hearing process
    c. Recipient Rights process

5. **When denial of hospitalization/Services/Supports occurs**, the applicant is provided with written notification of the following:

    a. Advance/Adequate Notice
    b. Second opinion process
    c. Request for Local Appeal
    d. DHHS Fair Hearing process (for Medicaid Consumers)
    e. Community Resource List

6. **When services are reduced, suspended or terminated outside the person centered planning/individual plan of service process** the recipient/legal representative is provided written notification of the following:

    a. Advance/Adequate Notice
    b. Request for Local Appeal
    c. MDHHS Fair Hearing process (for Medicaid Consumers)
    d. Community Resource List

D. When changing current services

1. Notice must be given at least 12 calendar days prior to reducing, suspending, or terminating currently authorized services for Medicaid Consumers.
2. Notice must be given at least 30 days prior to reducing, suspending, or terminating currently authorized services for Non-Medicaid Consumers.

3. Giving prior notice allows for the consumer to determine if they would like to appeal prior to the change in service happens.

E. Grievance Process

1. Recipients and/or their legal representative may request an informal resolution of a care concern through the following chain of command beginning with the recipient's case manager /primary therapist/supports coordinator, where their services are provided. The request may be presented in person, on the telephone or in writing.

2. The involved staff will arrange a time to discuss the request as quickly as possible and attempt to resolve the issue.

3. If the request involves an allegation of abuse or neglect, the individual will immediately be assisted in filing a recipient rights complaint.

4. If unable to resolve the care concern, the staff will assist the recipient/legal representative in submitting one or more of the following with the Customer Service Department: a local dispute/ grievance request, request for second opinion, request for a DHHS Fair Hearing (Medicaid enrollee only), or Recipient Rights Complaint with the CMHA-CEI Office of Recipient Rights, as requested. The recipient will be informed that appeals systems may be accessed simultaneously or sequentially.

5. A recipient/legal representative who wishes to file a grievance with the CMHA-CEI Customer Service Office may do so at any time.

6. Once the grievance is received by CMHA-CEI Customer Service Office, the Quality, Customer Service and Recipient Rights (QCSRR) Department shall review the grievance and send an acknowledgment letter within 5 business days.

7. The QCSRR Department will work with the programs to find a resolution to the grievance and send a disposition letter within 60 days. If the disposition letter is sent out after 60 days, the Medicaid recipient/legal representative will be informed of the right to request a DHHS Fair Hearing. The non-Medicaid recipient/legal representative will be notified of the right to request a DHHS Alternative Dispute Resolution hearing.

8. When the QCSRR Department receives a dispute/grievance hearing request, that request will be logged for evaluation.

9. Administrative documentation of the review and decision will include:

    a. Written notification to the recipient of the outcome of the dispute/ grievance review.

    b. A summary of the review process and copies of all supporting documents.

c. Reporting of the written dispute/grievance to be provided to the Quality Improvement and Compliance Committee on a quarterly basis.

d. Evidence that notification was provided to the recipient/legal representative of the right to request an DHHS Fair Hearing/DHHS Alternative Dispute Resolution process and/or file a recipient rights complaint, if applicable.

F. **Second opinion process**

1. Please refer to the Second Opinion Procedure, 3.6.17C for the process of second opinions

G. **Local Appeal Process**

1. A consumer and/or their legal representative may file a local appeal within 60 days of services they requested have been denied or their current services are terminated, suspended, or reduced.
2. The Customer Service Department is available to assist consumers to file the local appeal, if needed.
3. Local appeals are to be sent to the QCSRR Department.
4. The QCSRR Department will send the consumer or representative an acknowledgment letter within 5 business days.
5. The QCSRR Department will review the appeal and involve other parties as needed and send a disposition letter within 45 days.
6. When the QCSRR Department receives a local appeal, that request will be logged for evaluation.

H. **DHHS Fair Hearing Process**

1. The Fair Hearing Process may be requested whenever a Medicaid beneficiary/legal representative believes a decision by CMHA-CEI, affecting eligibility or services is inappropriate. (See Adequate notice and Advance notice of adverse action). The Department of Health and Human Services provides a Fair Hearing (Administrative Hearing) to hear the appeal.

2. An Alternative Dispute Resolution Process (Departmental Hearing) is available by request to individuals without Medicaid including beneficiaries of non-Medicaid Mich-Care and Children's Special Health Care Services Program (CSHCS) after local dispute/grievance processes have been exhausted.

3. All applicants/recipients - Medicaid enrolled or non-Medicaid or their legal representatives, must be informed in writing of their right to an appeal, (Hearing or Review), whenever hospitalization or service/supports are denied, suspended, reduced or terminated.

4. This notification of the right to appeal is provided with Advance/Adequate Notice of Adverse Action.

5. The role of the CMHA-CEI Fair Hearing Officer:

a. Prepare a clear statement of the action and/or decision(s) being appealed, including all programs involved in the action.

b. Identify facts which led to the action or decision. Best evidence cites Federal law (CFR), Mental Health Code, Chapter III of the Medicaid Regulations, the Mental Health Code and the DCH contract. Other evidence would include CMH policies and evidence of notice of due process (adequate or advance notice).

c. Provide the correct address of the appellant and/or authorized hearing representative (AHR).

d. Prepare a description of the documents intended to be offered as exhibits at the hearing.

e. Identify and ensure participation of necessary hearing/review witnesses from CMH who will testify.

f. Offer and, if appropriate, arrange a pre-hearing conference (see section ii below).

g. At the hearing/review:

i. Present opening statement
ii. Present facts/evidence
iii. Call and question CMH witnesses
iv. Cross-examine appellant/AHR and related witnesses.
v. Present closing statement

6. Pre-hearing conference

The fair hearing officer will work with the clinical program to offer a pre-hearing conference to the appellant/AHR. The purpose of the pre-hearing conference is to explore the issues to be brought to the DHHS hearing/review and determine if a settlement can be reached prior to the hearing.

- If settlement can be reached, the appellant may withdraw the Hearing/Review request.

7. DHHS Fair Hearing Review

The Hearing Review will be conducted at a mutually agreeable site or by teleconference. CMHA-CEI must make every effort to arrange for the appellant to be present for the hearing/review. The hearing/review will be conducted and a decision reached within 90 days of the date of the hearing/review request.

I. Alternative Dispute Resolution Process for recipients without Medicaid who are unhappy with the local appeal process.

1. CMHA-CEI notifies the non-Medicaid recipient/legal representative of the right to an Alternative Dispute Resolution process from DHHS after local appeals/grievance processes have been exhausted.

2. The appellant has 10 days from the date of written notification of the outcome of the local dispute/grievance resolution process to request the Alternative Dispute Resolution Process.

3. Requests may be submitted in any written form, but must contain the following information:
   a. Name of recipient
   b. Name of guardian legally empowered to make treatment decisions or parent of minor child.
   c. Daytime phone number where the consumer, guardian or parent may be reached.
   d. Name of the CMHA-CEI where services have been denied, suspended, reduced or terminated.
   e. Description of the service being denied, suspended, reduced or terminated.
   f. Description of the adverse impact on the consumer caused by the denial, suspension, reduction or termination of service.

4. The request should be directed 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-5th FL
   Lansing, MI 48913

J. Appeal after Denial of Hospitalization

1. Following a screening for hospitalization, if the applicant is determined to not meet criteria they receive notice or the right to a second opinion.
2. If requested, the second opinion must occur within 24 hours of the request.
3. The second assessment is completed by a professional (psychiatrist, physician, or fully licensed psychologist) not involved in the initial determination.
4. Crisis/Emergency Services is responsible to receive, document, and respond to these requests.

K. Denial of Family Support Subsidy

1. When the Family Support Subsidy is denied or terminated the applicant/recipient/legal/representative is provided written notification of the right to appeal.
2. The QCSRR Department is responsible to receive, document, and respond to the family support subsidy appeal.

L. Timeframes

1. When denying services, notice must be given to the consumer/legal representative at the time the program makes the decision to deny services.
2. When reducing, suspending, or terminating current services, the program must give at least 12 days' notice to Medicaid beneficiaries and at least 30 days for non-Medicaid beneficiaries.
3. Grievances will be responded to within 60 calendar days.
4. Local appeals will be completed within 45 calendar days, unless the consumer has requested an expedited resolution and CMHA-CEI grants the expedited process. Expedited appeals will be responded to within 3 working days.

III. Definitions:

A. **Adequate Notice -** Information provided about the right to a Department of Health and Human Services Fair Hearing/DHHS Alternative Dispute Resolution process to applicants/recipients of services and/or their legal representatives, at the time an Individual Plan of Service (IPOS) is developed or modified through the person centered planning process or whenever a decision is made to deny a CMHA-CEI service or support.

B. **Administrative Hearing/Fair Hearing -** An impartial review of a decision made by CMHA-CEI/contract agency that the beneficiary, who is Medicaid enrolled, believes is inappropriate. The impartial review is completed by an administrative law judge as an agent of DHHS.

C. **Alternative Dispute Resolution Process:** For persons seeking services from CMHA-CEI, who are not enrolled in Medicaid, an impartial review of a decision that the recipient believes is inappropriate. The impartial review is completed by an agent of DHHS.

D. **Administrative Law Judge (ALJ) -** A person designated by DHHS to conduct the Administrative Hearing in an impartial or unbiased manner

E. **Advance Notice -** Information provided to a recipient of mental health services or his/her legal representative whenever a decision (adverse action) to suspend, reduce or terminate Medicaid covered services is made outside the person centered planning process OR when services that are part of a current treatment plan are reduced suspended or terminated without agreement of the recipient/legal representative, whether or not the change occurs as part of person centered planning. Notice must be mailed at least 12 business days in advance of the date of action.

F. **Adverse Action -** Services are denied, reduced, suspended, or terminated as a result of a utilization review or outside of the regular treatment planning process. When the utilization review process is not part of the organization, any suspension, reduction, or termination of service which occurs outside of the person centered planning process or without written physician prescription is considered an adverse action.

G. **Appeal -** An application to a higher body for a decision.

H. **Appellant -** A recipient/consumer, parent of a minor child or guardian who disagrees with a limitation on mental health service by filing a grievance, dispute or fair hearing request.

I. **Applicant -** A person or his/her legal representative who requests mental health services/hospitalization. (For this purpose it may be a request for a new service by a current recipient or a request for services from an individual who has not previously or is not currently receiving services).

J. **Authorized Hearing Representative (AHR) -** The person who stands in for or represents the beneficiary in the administrative hearing process and has the legal right to do so. This right comes from one of the following sources:

- Written authorization, signed by the beneficiary, giving a person authority to act for the beneficiary in the hearing process.
- Court appointed guardian or conservator.
- Legal parent of a minor child
- The beneficiary's spouse, or the deceased beneficiary's widow or widower, ONLY when no one else has the authority to represent the beneficiary.

An AHR has no right to a hearing, but rather exercises the beneficiary's right. Someone who assists, but does no stand in for or represent the beneficiary in the hearing process, does not need to meet the above criteria.

K. **Beneficiary -** An applicant or recipient of Medicaid or other DCH medical benefits.

L. **Dispute -** A disagreement regarding an adverse action submitted by a non-Medicaid covered recipient, or his/her legal representative.

M. **Grievance -** A disagreement regarding an adverse action submitted by a Medicaid enrollee or his/her legal representative.

N. **Fair Hearing Officer -** A person located at Community Mental Health who is the liaison person between CMHA-CEI and the ALJ.

O. **Hearing Presenter -** A person who prepares for and represents CMHA-CEI at the Administrative Hearing.

P. **Legal Representative -** Parent of a minor child or an empowered guardian.

Q. **Recipient -** An individual who receives mental health services from Community Mental Health or from a provider under contract with Community Mental Health.

R. **Second Opinion -** A request by an applicant for mental health services, a recipient seeking hospitalization or their legal representative for another assessment by a professional who was not involved in the original assessment, for eligibility for mental health services/hospitalization.

S. **Staff -** Employees of CMHA-CEI.

IV. Monitor and Review:

This procedure is reviewed annually by the Director of Quality, Customer Service, and Recipient Rights. This procedure is monitored by accrediting bodies and regulatory agencies as applicable.

V. References:

A. Grievance and Appeal Technical Requirement PIHP Grievance System for Medicaid Beneficiaries

B. Michigan Mental Health Code (MHC), Act 258 of the Public Act of 1974, as amended, 330.1159, 330.1409 (4), 330.1498e(4), 330.1498h(5), 330,1705, 330.1712(2), 330.1772-1788.

C. Michigan Department of Health and Human Services/Community Mental Health Service Provider Specialty Services Managed Care Contract Section 6.3

D. Mid-State Health Network/Community Mental Health Services Specialty Services Managed Care Contract Section XXI.

VI. Related Policies and Procedures:

CMHA-CEI Policy	3.6.17	Appeals and Grievances

VII. Review Log:

Review Date	Reviewed By	Changes (if any)
03/16/04	-	-
06/10/05	-	-
11/20/07	-	-
04/15/11	-	-
05/26/14	-	-
04/20/17	QCSRR Director	Updated to new format

VIII. Attachments:

A. Advance/Adequate Notice
B. Local Appeal/Grievance Request Form
C. Fair Hearing Request Form