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CLIENT SERVICES
(Manual Section)

Grievances & Appeals Process
(Subject)

Approval of Policy:	Dated:
Policy Inception Date:	November 12, 1998
Last Revision of Policy Approved:	
[signed by Nena Sork]	June 17, 2024

•1 POLICY:

It is the policy of the Agency that all individuals served and applicants for service have the right to a fair and efficient process for resolving disagreements regarding their services and supports.

All individuals receiving services are to be informed of the grievance process orally and in writing at the time of initial service, at the time the treatment plan is signed, and whenever they request if they are not satisfied with decisions regarding services and supports they are receiving or have requested.

Appeals and grievances are accepted either orally or in writing. A letter of acknowledgement will be sent to the complainant, and resolution to the complaint will be accomplished within required timeframes, with a written report sent to the complainant.

For grievances regarding denial of expedited resolution of an appeal and for grievances that involve clinical issues, the grievance is to be reviewed by health care professionals who have the appropriate clinical expertise in treating the individual's condition. Resolution of the appeal or grievance will be facilitated as expeditiously as the individual's health condition requires.

An individual served or their individual representative must be offered an opportunity to request mediation to resolve a dispute between the recipient or their individual representative and the CMH related to planning and providing services or supports to the recipient.

The CMH shall provide notice to an individual served, or their individual representative, of the right to request and access mediation at the time services or supports are initiated and at least annually after that. When the CMH local dispute resolution process, local appeals process, or state Medicaid fair hearing is requested,

notification of the right to request mediation must also be provided to the individual served or their individual representative.

The CMH must participate in mediation if mediation is requested.

Mediation does not prevent an individual served or their individual representative from using other appeal options. The parties may agree to voluntarily suspend other appeal options, unless prohibited by law or precluded by a report of an apparent or suspected violation of rights delineated in Chapter 7.

If the dispute is resolved through the mediation process, a legally binding document is signed and is enforceable in any court of competent jurisdiction in this state.

The grievance and appeal process is a delegated function of the Prepaid Inpatient Health Plan (PIHP) Grievance and Appeal Protocol.

•2 APPLICATION:

All applicants/individuals served

•3 DEFINITIONS:

Adverse Benefit Determination (ABD): A decision that adversely impacts the Medicaid and non-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, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
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. In the unlikely event of a denial of payment for services rendered, an ABD notice will be sent by the person making the decision to deny payment and sent the same date the claim denial is determined.
4. Failure to act within the appeal and grievance timeframes as established in this policy.
5. Failure to provide Medicaid or non-Medicaid covered services in a timely manner (14 days).
6. Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of recipient of a standard request for service.
7. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization.

Adequate Notice of ABD: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services that have been requested. Notice is provided on the same day the ABD takes effect.

Advance Notice of ABD: A written statement advising the beneficiary/individual of a decision to suspend, reduce or terminate a Medicaid or non-Medicaid covered service they are currently receiving. Notice must be mailed at least ten (10) calendar days prior to the proposed date the ABD takes effect for a Medicaid beneficiary and thirty (30) calendar days in advance of the date of action for a non-Medicaid individual.

Appeal: A review at the local level of an ABD relative to a Medicaid covered service or non-Medicaid covered service.

Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

Expedited Appeal: The expeditious review of an ABD requested by an individual or the individual's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the individual's life, physical, or mental health, or ability to attain, maintain, or regain maximum function. If the individual requests the expedited review, the PIHP/CMH determines if the request is warranted. If the individual's provider makes the request, or supports the individual's request, the PIHP/CMH must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by an Administrative Law Judge. Also referred to as an Administrative Fair Hearing.

Grievance: An expression of dissatisfaction about any service issue other than an ABD. The term may also refer to the general system of appeals and grievances. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationship between a service provider and the individual receiving services.

Grievance Process: Impartial local level review of the individual's grievance. There is no further appeal or Fair Hearing rights unless the CMH fails to comply with State timeframes.

Individual Served: A person receiving mental health services delivered and/or managed by the CMH including persons with Medicaid and all others.

Local Appeal Process: Impartial local level and/or PIHP level review of an individual's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the Medicaid state plan or Habilitation Supports Waiver.

Recipient Rights Complaint: A written or verbal statement by an individual served or anyone acting on behalf of the individual alleging a violation of a protected right by the Michigan Mental Health Code. Recipient Rights Complaints are resolved through the Office of Recipient Rights as established in Chapter 7A.

Service Authorization: The PIHP/CMH 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. Standard service authorizations that limit or deny services must be completed within 14 days for both the Medicaid beneficiary and non-Medicaid individual.

•4 REFERENCES:

Federal Register, Part 42CFR, 440.2030(d)

Northern Michigan Regional Entity (NMRE) Grievance and Appeal Protocol, Fair Hearing Protocol #07-03-001

Michigan Mental Health Code, Act 258 of the Public Acts of 1974, as amended, Chapter 7, 7a, 4 and 4a, and 2 and 2a.

Michigan Department of Health and Human Services Medical Services Administration, Community Mental Health Services Program Manual, Chapter III.

Michigan Department of Health and Human Services Medical Services Administration Bulletin, Beneficiary Eligibility Manual Beneficiary Hearings Chapter l, Section 2.

Michigan Department of Health and Human Services Appeal and Grievance Resolution Processes, Technical Requirement, Revised July 29, 2020.

Michigan Department of Health and Human Services (MDHHS)/Community Mental Health Service Provider (CMHSP) Specialty Services Managed Care Contract 4.7.4.

Person-Centered Planning Guideline.

•5 FORMS AND EXHIBITS:

Exhibit A – Request for Second Opinion
Exhibit B – Request for Local Appeal
Exhibit C – Grievance Request
Exhibit D – Recipient Rights Complaint
Exhibit E – Recipient Rights Complaint Process Flow Chart

Exhibit F – Letter of Ineligibility
Exhibit G – Appeal Request
Exhibit H(1) – Receipt of Appeal
Exhibit H(2) – Notice of Untimely Appeal
Exhibit I – Decision of Hearing
Exhibit J – Request for an Administrative Hearing
Exhibit K – Request for Withdrawal of Appeal
Exhibit L – Hearing Summary (DCH – 0367)
Exhibit M – Order Certification (DCH - 0107)
Exhibit N – Request for Review by the Department of Health and Human Services
Exhibit O – Time Frames for Requests and Resolutions of Grievance and Appeals

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•6 PROCEDURE:

Grievance and Disputes over Decisions regarding Services and Supports

•6•1 APPLICATION:

All applicants/individuals served

•6•2 OUTLINE / NARRATIVE:

1. Whenever possible, disputes will be resolved at the level closest to service delivery.

2. This Agency will provide the PIHP with a copy of their Grievance, Appeals and Dispute resolution policies, including attachments and copies of forms and brochures.

    A. Customer Services will serve in the capacity of coordinating disputes at the local level. The name and phone number of the coordinator will be displayed on brochures and posters, explaining the appeal and grievance process.
    B. Customer Services will keep data about the number, scope and resolution of appeals and grievances.
        1) Data logs will be submitted to and tabulated by the PIHP quarterly.
        2) When a grievance is received, Customer Services will log the complaint and refer the grievance to the appropriate person for handling the dispute.
        3) Customer Services will assist the applicant (if requested) in filing an appeal at the local, PIHP and state levels.

3. There are five different types of dispute processes. They include:
    A. Second Opinion (for denial of initial services and/or inpatient hospitalization).
    B. Recipient Rights for rights violations or a denial of a request for a second opinion.
    C. Local Appeals and Grievance processes.
    D. MDHHS Administrative Fair Hearing for Medicaid Recipients.
    E. MDHHS Alternative Dispute Resolution Process for Non-Medicaid Recipients.

4. This Agency will orientate the individual served:
   A. at the time of the initial assessment.
   B. by posting notices of recipient protection systems in areas frequented by individuals receiving services.
   C. by having written material available to provide to the individual describing the recipient's protection systems that are required by contract and federal law.

5. A denial of service may occur as a result of any of the following:
   A. Following the assessment for services when the presenting symptoms or issues do not meet medical/clinical necessity and intensity criteria.
   B. Request by the individual receiving services or a provider with the individual's written consent for a service different than the services agreed upon in the individual plan of service developed through the person-centered planning process.
   C. Following an assessment for a request for inpatient hospitalization.
   D. After admission to an inpatient unit, and upon the request for continued stay in an inpatient setting, if the presenting symptoms do not support continued hospital care.
      1) Provide the individual, and, if appropriate, the provider, with the notice and appeal rights.
      2) Applicants will never be denied emergency treatment.
      3) When access to services or continued stay in an inpatient setting are denied:
         a. Adequate Notice of Adverse Benefit Determination will be provided to the person requesting services, and, if involved, the provider with the individual's written consent, noting that the notice to the provider does not have to be in writing.
         b. Notice will be provided the day of the denial or be mailed no later than the day of the denial and must contain:
            i. what services were requested.
            ii. reason for the denial
            iii. information about recipient protection systems (grievance and appeals)
            iv. right to request a second opinion and the process to request a second opinion
            v. right to an administrative fair hearing or MDHHS Alternative Dispute process
            vi. time frames in which to file an appeal

6. Quarterly reports of grievances and complaints will be reported to the Risk Management Committee, Quality Improvement Council, NeMCMHA Board, and the PIHP Customer Services Department.

7. The grievance and appeal process requires the following:

   A. A beneficiary/individual served may request a local appeal of an "Action" within 60 calendar days from the date of the notice of action for Medicaid beneficiaries and 30 calendar days for non-Medicaid individuals.
   B. The request may be oral or in writing. If oral, the request must be confirmed in writing unless expedited resolution was requested. The request for an appeal will be acknowledged, in writing, to the appellant within five (5) business days.
   C. The beneficiary/individual served has a right to an expedited local appeal if waiting for the standard time for a local appeal (30 calendar days for Medicaid beneficiaries and 45 calendar days for non-Medicaid individuals) would seriously jeopardize the health or would jeopardize the individual's ability to attain, maintain or regain maximum function. An expedited appeal must be resolved and Notice of Disposition provided within 72 hours. If the request for an expedited appeal has been denied, timeframes for a standard appeal apply. The beneficiary/individual served must receive prompt oral notice of the denial and follow up with written notice within two (2) calendar days.
   D. If the beneficiary/individual receiving services requests the local appeal within ten (10) calendar days of the notice, and requests that services continue, the service must be continued until a determination is reached. If the appeal is upheld, the individual may be billed for the cost of service.
   E. The appeal must be resolved within thirty (30) calendar days from the date the appeal was received for a Medicaid beneficiary and sixty (60) calendar days for non-Medicaid individuals.
   F. A grievance is a statement of dissatisfaction with any aspect of a Medicaid covered or non-Medicaid covered service that is not an Adverse Benefit Determination. A grievance must be resolved within ninety (90) calendar days of receipt of the grievance for Medicaid beneficiaries and sixty (60) calendar days for non-Medicaid individuals.
   G. Reasonable assistance will be afforded to the beneficiary/individual receiving services to complete forms and other procedural steps including but not limited to interpreter services.
   H. Persons hearing the local appeal will not have previous involvement in review or decision-making and are clinician(s) with an appropriate background.
   I. For grievances or appeals regarding denial of expedited resolution of an appeal and for a grievance or appeal that involves clinical issues or medical necessity, the grievance or appeal is reviewed by health care professionals who have the appropriate clinical expertise in treating the beneficiary's/consumer's health condition. Resolution of the

appeal or grievance will be facilitated as expeditiously as the beneficiary's/individual's health condition requires.

J. The beneficiary/individual receiving services must be provided a reasonable opportunity to present information in person and/or in writing concerning the complaint. The beneficiary/individual receiving services may also include their representative in the grievance/appeal process. They may request, before or during the appeal process, to review the beneficiary's/individual's case file, including medical record and any other documents and records considered during the appeal process.

K. Notice of disposition of a grievance or appeal includes:
   1) An explanation of the decision.
   2) The beneficiary's/individual's options for further dispute, including the State Fair Hearing process and how to access the process.
   3) An explanation of their right to continue to receive services pending resolution of the State Fair Hearing process if requested within ten (10) calendar days.
   4) The potential obligation to pay for services if the beneficiary/individual receiving services is unsuccessful in the hearing process.
   5) The date of the disposition.

L. The PIHP/CMH may extend the resolution and notice time frames of a grievance or appeal by up to 14 calendar days if the individual requests an extension, or if the PIHP/CMH shows to the satisfaction of the State there is a need for additional information, and how the delay is in the individual's interest.

M. If time frames are extended, the PIHP/CMH must make reasonable efforts to give oral notice of the delay to the individual, give written notice of the reason for the extension within two (2) calendar days, and inform the individual of the right to file a grievance if the individual disagrees. The appeal should be resolved as quickly as the individual's health condition requires, and not later than the date the extension expires.

•6•3 CLARIFICATIONS:

•6•4 CROSS-REFERENCES:

•6•5 FORMS AND EXHIBITS:

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•7 PROCEDURE:

Providing Notice of Rights

•7•1 APPLICATION:

All applicants/individuals receiving services

•7•2 OUTLINE/NARRATIVE:

- **Action Notice – Individual Plan of Service (IPOS)**

  This notice is provided to the individual receiving services, guardian, or parent of a minor along with a copy of the IPOS, developed through the Person-Centered Planning process. (The IPOS must be given within fifteen (15) business days of the planning meeting.) Should the individual/guardian/parent of a minor indicate a desire to exercise their appeal options, the appropriate forms should be provided.

- **Adequate Notice of Adverse Benefit Determination**

  1. Denial of Initial or Inpatient Services – This notice is provided when an applicant is denied initial mental health services and when an applicant/individual receiving services is denied inpatient hospitalization. The original notice is given to the applicant/individual, guardian, or parent of a minor, with a copy to the file. Should the applicant/individual/guardian/parent of a minor indicate a desire to exercise their appeal options, the appropriate forms should be provided.
  2. Denial of Additional Services/Delays – This notice is provided to the individual receiving services, guardian, or parent of a minor when a request is made and service was denied, when the authorized service will be delayed and/or a decision was delayed regarding a requested service.

- **Advance Notice of Adverse Benefit Determination**

  This notice is required when an action is being taken to reduce, suspend, or terminate a benefit or service the individual is currently receiving. The notice must be mailed at least ten (10) calendar days before the intended

negative action takes effect for a Medicaid beneficiary or thirty (30) calendar days for a non-Medicaid individual. The action is pended to provide the individual a chance to react to the proposed action. If the individual requests an appeal before the date of action, the Agency may not terminate or reduce benefits or services until a decision has been reached through the appeal process. If the individual receiving services wants the service(s) to continue during the appeal process, they may be billed for all or part of the costs of those services up to their ability to pay, as determined by the Mental Health Code, if the appeal process does not reverse the original action to reduce, suspend, or terminate the service(s).

The conditions under which there is an exception to providing the Advance Notice of Adverse Benefit Determination are as follows:

A. The notice may be mailed not later than the date of action if:
   1. The Agency has factual information confirming the death of the individual served.
   2. The Agency receives a clear written statement signed by the individual receiving services or their legal representative that they no longer wish to receive services or give 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 receiving services has been admitted to an institution where they are ineligible under Medicaid for further services.
   4. The individual's whereabouts are unknown and the post office returns mail directed to them indicating no forwarding address.
   5. The Agency establishes the fact that the individual has been accepted for Medicaid services by another community mental health board.
   6. A change in the level of medical care is prescribed by the individual's physician.

B. The period of advance notice may be shortened to five (5) days before the date of action if the Agency has facts indicating the action should have been taken because of probably fraud and these facts have been verified, if possible, through secondary sources.

- **Request for a Second Opinion (Exhibit A)**

This request form is provided to an applicant for services who has been denied services and an applicant/individual who has been denied hospitalization, and a desire has been expressed to exercise this appeal option. Upon completion of the request form, a copy is given to the

applicant/individual upon receipt by the CMH worker. The original is forwarded immediately to Customer Services. When the request is for hospitalization, a photocopy should be forwarded to the Agency Executive Director and the Medical Director.

- **Request for Local Appeal (Exhibit B)**

  This request form is provided when an applicant/ individual served/ guardian/ parent of a minor has indicated a desire to exercise this appeal option. Upon receipt of the completed request, the original is forwarded to Customer Services with a copy retained by the applicant/individual served/guardian/parent of a minor. Customer Services will log, acknowledge receipt of the request within five (5) business days, and forward the request to the appropriate individual for review and response.

- **Grievance (Exhibit C)**
  This request form is provided when an applicant/ individual served/ guardian/ parent of a minor has indicated a desire to exercise this grievance option. Upon receipt of the completed request, the original is forwarded to Customer Services with a copy retained by the applicant/ individual served/ guardian/ parent of a minor. Customer Services will log, acknowledge receipt of the request within five (5) business days, and forward the request to the appropriate individual for review and response. A grievance may be filed at any time. A response must be provided within ninety (90) calendar days for a Medicaid beneficiary and sixty (60) calendar days for a non-Medicaid individual.

•7•3 CLARIFICATIONS:

•7•4 CROSS-/REFERENCES:

•7•5 FORMS AND EXHIBITS:

Exhibit A – Request for Second Opinion
Exhibit B – Request for Local Appeal
Exhibit C – Grievance

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	May 10, 2021

•8 PROCEDURE:

Informal Review with NeMCMHA Worker and/or Worker's Supervisor

•8•1 APPLICATION:

All individuals receiving services

•8•2 OUTLINE/NARRATIVE:

The individual receiving services/guardian may request an informal resolution of an issue with their Agency worker and/or supervisor. These individuals' names and phone numbers are provided to the individual served/guardian in the Plan of Service.

The dispute or grievance can be presented in person, on the telephone or in writing. Upon receipt of the request, the Agency employee shall forward it to Customer Services to log the request and retain it.

The worker or supervisor will arrange a time to discuss the dispute or grievance without undue delay and will attempt to resolve the issue with the individual receiving services/guardian.

If the issue involves an issue of abuse or neglect, the worker or supervisor will immediately assist the individual/guardian in filing a Recipient Rights complaint.

Summary notes of the meeting/telephone call to attempt to resolve the issue shall be retained by Customer Services.

•8•3 CLARIFICATIONS:

•8•4 CROSS-/REFERENCES:

•8•5 FORMS AND EXHIBITS:

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•9 PROCEDURE:

Second Opinion – Denial of Hospitalization

•9•1 APPLICATION:

All Affiliation contracted inpatient programs

•9•2 OUTLINE / NARRATIVE:

If the pre-admission screening unit or children's diagnostic and treatment service denies hospitalization, the individual, their guardian or their parent in the case of a minor child, may request a second opinion from the Agency's Executive Director.

Upon request, the Request for a Second Opinion (Exhibit A) must be given to the applicant/individual who has been denied hospitalization. If an applicant/individual is not able to complete the request, the individual may request assistance from Customer Services, or any other staff person.

Upon receipt of the Request for a Second Opinion, the Executive Director/designee will forward a copy of the request to Customer Services, who will maintain a log and report to designated staff at the PIHP for recording and trending purposes on a quarterly basis.

The Executive Director/designee shall arrange for an additional evaluation by a psychiatrist, other physician, or fully licensed psychologist within three (3) calendar days excluding Sundays and legal holidays, after the Executive Director receives the request.

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 Executive Director/designee, in conjunction with the Medical Director, shall make a decision within one (1) business day based upon all clinical information available. The Executive Director's decision shall be confirmed in writing to the individual who requested the Second Opinion, and the confirming document shall include the signatures of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director. If an individual is assessed and found not to be clinically

suitable for hospitalization, the preadmission screening unit shall provide appropriate referral services.

•9•3 CLARIFICATIONS:

•9•4 FORMS AND EXHIBITS:

•9•5 FORMS AND EXHIBITS:

Exhibit A – Request for a Second Opinion

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•10 PROCEDURE:

Second Opinion – Denial of Initial Services

•10•1 APPLICATION:

All Agency programs

•10•2 OUTLINE / NARRATIVE:

When an applicant requesting service is denied mental health service, they must be informed of their right to request a second opinion of the Executive Director/designee. This is done via the Adequate Notice of Adverse Benefit Determination.

Upon request, the Request for a Second Opinion (Exhibit A) must be given to the applicant who has been denied initial services. If an applicant is not able to complete a written request, the individual may request assistance from Customer Services or any other staff person.

Upon receipt of the Request for a Second Opinion, the Executive Director/designee will forward a copy of the request to Customer Services, who will maintain a log and report to designated staff at the PIHP for recording and trending purposes on a quarterly basis.

The Executive Director/designee shall secure the second opinion from a physician, licensed psychologist, Registered Nurse (RN), master's level social worker, or a master's level psychologist within five (5) calendar days.

If the clinician providing the second opinion determines that the applicant meets criteria for services or is experiencing an emergent or urgent situation, services shall be offered to the applicant.

Written notice of the results of the second opinion shall be given to the applicant within one (1) business day.

The applicant may not file a recipient rights complaint for denial of services suited to condition as the applicant does not have standing as an individual served by the Agency. They may, however, file a rights complaint if the request for a second opinion is denied.

•10•3 CLARIFICATIONS:

•10•4 CROSS-/REFERENCES:

•10•5 FORMS AND EXHIBITS:

Exhibit A – Request for a Second Opinion

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•11 PROCEDURE:

Recipient Rights Complaint

•11•1 APPLICATION:

All individuals receiving services

•11•2 OUTLINE / NARRATIVE:

Investigative Procedure:

Upon receipt of each rights complaint, the rights office shall record the complaint. A letter of acknowledgement along with a copy of the complaint is sent to the complainant within five (5) business days. If no investigation is warranted, the complainant is notified of such within five (5) business days.

The rights office will assist the individual receiving services or other individual with the complaint process as necessary. The rights office will advise the individual receiving services or other individual that there are advocacy organizations available to assist in preparation of a written rights complaint and will offer to make a referral. In the absence of assistance from an advocacy organization, the rights office will assist in preparing a written complaint, which contains a statement of the allegation, the right allegedly violated and the outcome desired by the complainant.

A written status report must be issued every thirty (30) days during the course of the investigation. Those individuals receiving a copy of the report are the complainant, respondent and the responsible mental health agency (RMHA).

The 30-day status report must contain the following:

a. Statement of allegations.
b. Statement of issues involved.
c. Citations to relevant provisions to the Mental Health Code, rules, policies and guidelines.
d. Investigative progress to date.
e. Expected date for completion.

The rights office will use a preponderance of the evidence as its standard of proof to determine whether a right was violated.

On substantiated rights violations, the respondent and/or Agency will take appropriate remedial action meeting all the following requirements:

a. Corrects or provides remedy for the rights violation.
b. Is implemented in a timely manner.
c. Attempts to prevent a recurrence of the rights violation.

The Executive Director or their designee shall then submit a written summary report to the complainant and recipient, if different than the complainant, within ten (10) business days after the Executive Director receives a copy of the investigative report from the rights office.

The summary report above shall contain all of the following:

a. Statement of allegations.
b. Statement of the issues involved.
c. Citations to relevant provisions of the Mental Health Code, rules, policies and guidelines.
d. Summary of investigation findings of the rights office.
e. Conclusions of the rights office.
f. Recommendations made by the rights office.
g. Action taken or plan of action proposed by the respondent/CMH.
h. A statement describing the complainant's right to appeal and the grounds for appeal.

When a Code right is protected, but it is not a complaint alleging abuse, neglect, retaliation or harassment, and the facts are clear (undisputed), the complaint may be handled informally at the discretion of the Recipient Rights Officer. This is known as an **intervention**.

•11•3 CLARIFICATIONS:

•11•4 CROSS-/REFERENCES:

•11•5 FORMS AND EXHIBITS:

Exhibit D – Recipient Rights Complaint (DCH-0030)
Exhibit E – The Recipient Rights Complaint Process Flow Chart

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•12 PROCEDURE:

Local Dispute Resolution Process

•12•1 APPLICATION:

All individuals receiving services

•12•2 OUTLINE / NARRATIVE:

When an individual served by any Agency program is dissatisfied with an Individual Plan of Service offered to address their mental health needs, or services have been denied, reduced, suspended, or terminated, the individual may request a local appeal. The Request for Local Appeal (Exhibit B) should be provided to the individual receiving services whenever there is an indication that the individual wishes to exercise this appeal option. Upon receipt of the completed form from the individual, it shall be forwarded to Customer Services who will log the request, acknowledge receipt, and assign to the appropriate individual to address.

•12•3 CLARIFICATIONS:

•12•4 CROSS-/REFERENCES:

•12•5 FORMS AND EXHIBITS:

Exhibit B – Request for Local Appeal

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	June 17, 2024

•13 PROCEDURE:

Denial of Family Support Subsidy

•13•1 APPLICATION:

To all Board programs

•13•2 OUTLINE/NARRATIVE:

If an application for a family support subsidy is denied or a family support subsidy is terminated, the parent or legal guardian of the affected eligible minor may request, in writing, a hearing with NeMCMHA.

The written appeal shall be filed with the Executive Director within two (2) months of the notice of denial or termination. (See Exhibit F)

Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from NeMCMHA.

NeMCMHA shall review an application and promptly approve or deny the application and shall provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision (See Exhibit F) 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 Agency shall identify the insufficiency.

The hearing shall be conducted in the same manner as provided for contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969.

Upon receipt of the request for appeal, the Executive Director/designee will forward a copy of the request to Customer Services, who will maintain a log. Contents of the log are provided on a quarterly basis to the designated staff at the PIHP for recording and trending purposes.

A receipt of Appeal (Exhibits H(1) and H(2)) shall be sent to the individual indicating the information about the scheduled hearing (H(1)), or a response indicating that the appeal was not received within two (2) months of the action (H(2)).

The notice of the hearing shall include:
1. Date, hour, place, and nature of hearing,
2. Statement of legal authority and jurisdiction under which the hearing is to be held,
3. Reference to statues and rules involved, and
4. Short and plain statement of the matters asserted.

The Executive Director/designee shall:
1. Preside as the hearing officer,
2. Not talk with one side regarding the contested case without the other being present,
3. Not do any investigation or fact finding, (each side must show the Executive Director/designee why that side should prevail),
4. Become familiar with the law and rules governing the contested matter,
5. Read the correspondence from both sides prior to the hearing.

The hearing shall be tape-recorded. The Executive Director/designee shall begin the tape by identifying the date, time, place, and nature of the appeal.

The Executive Director/designee will state the processes:
1. I will ask all parties present to identify themselves for the record (names and functions – include self).
2. I will swear in all those present who may want to say something.
3. I will show you this file and ask if you object to anything that it contains – there should only be items which both parties have received or of which they had notice.
4. I will ask the representative from Family Support Subsidy Program to explain why they denied or terminated the family from the subsidy program.
5. I will ask the family if they have questions about what the Family Support Subsidy person has said.
6. I will ask the family to explain what the Family Support Subsidy Program should have considered – but didn't.
7. I will ask the Family Support Subsidy program representative if there are any questions about what the family said.
8. I will then ask each party if it has anything to add.
9. Finally, I will announce my findings today, and give you a decision which will end this hearing. (or) I will go back to my office and issue a written opinion as to my findings of facts and conclusions of law and give you a decision in the near future. If you do not agree with my decision at the time the decision is made, you may appeal to circuit court.

Proceed with the hearing.

Pointers regarding the process:

1. All those present should identify themselves – even if they don't plan to speak.

2. The swearing in can be done as a group. Encourage even those not planning to speak to respond. Say to them: Raise your right hand. Do you affirm or swear that you will tell the truth, the whole truth, and nothing but the truth? If so answer, I do.

3. Open the file, identify each item, then hand each to pass around. For example, "This is the original appeal complete with attachments which came to our office. Please look at it." After all items have been looked at, ask whether anyone objects to anything in this file.

4. Ask the Family Support Subsidy Program person to explain why the family was denied or terminated. If the family interrupts, ask them to wait – they will have a turn. Throughout the hearing, the Presiding Officer may choose whether to ask questions for clarification or to leave the burden of clarification to the other side.

5. Ask the family if they have questions – for clarification or additional information. Keep everyone on task. Allow only questions right now – they will have an opportunity to make their statement. Try not to allow interruptions. Remind parties they must be testifying, questioning, or addressing the Presiding Officer and not debating each other.

6. Ask the family to explain what the Family Support Subsidy Program should have considered.

7. Allow questions from the Family Support Subsidy Program person.

8. Allow the final remarks from both sides.

9. The Presiding Officer may choose whether to give the findings of fact, and the conclusions of law orally at the end of the hearing or issue a written decision. If the Presiding Officer is not fully familiar with the law, the format, and the process, written findings, conclusion, and decision might be preferable. (Exhibit I)

10. The written decision should be issued promptly.

11. If an individual fails to appear, and no adjournment is granted, the Executive Director/designee may proceed with the hearing.

•13•3 CLARIFICATIONS:

•13•4 CROSS-/REFERENCES:

•13•5 FORMS AND EXHIBITS

Exhibit F – Letter of Ineligibility
Exhibit G – Appeal Request
Exhibit H(1) – Receipt of Appeal
Exhibit H(2) – Notice of Untimely Appeal
Exhibit I – Decision of Hearing

Administrative Approval of Procedure:	**Dated:**
[signed Nena Sork]	May 10, 2021

•14 PROCEDURE:

Administrative Fair Hearing

•14•1 APPLICATION:

All individuals served who are Medicaid beneficiaries

•14•2 OUTLINE / NARRATIVE:

A Medicaid beneficiary or his/her legal representative has one hundred twenty (120) calendar days from the date of the notice of appeal resolution to request a Fair Hearing. A Fair Hearing may only be requested AFTER exhausting the local appeal process, OR if the CMH fails to comply with State time frames for a grievance or appeal.

A DCH-0092 (Exhibit J), Request for Hearing Form and a return postage paid envelope shall be provided to the applicant/individual when requested. All hearing requests must be in writing and provide the name, address and telephone number of the person for whom the hearing is being requested. The name, address and telephone number of the person requesting the hearing, if different, should be included. The benefit or program involved should be clearly identified. The hearing request should identify what decision is being challenged. The form should be signed by the appellant affected by the determination of his/her Authorized Hearing Representative (AHR). All hearing requests should be mailed to:

Michigan Office of Administrative Hearings and Rules (MOAHR)
PO Box 30763
Lansing, MI 48909
FAX: (517) 763-0146

HEARING SUMMARY

Upon receipt of a hearing request, the Tribunal will assign a docket number and fax a copy of the hearing request to the Agency identified in the hearing request. A hearings coordinator will be designated by the Agency and is responsible for receiving the hearing requests, identifying the responsible staff and forwarding a completed hearing summary to the Tribunal and the Appellant within fourteen (14) days of receipt of the hearing request.

The Hearing Summary form (Exhibit L), or its equivalent, must include all of the following:

- Clear statement of the action and/or decision being appealed, including all programs involved in the action.
- Facts which led to the action or decision.
- Policy which supported the action or decision.
- Correct address of the Appellant or AHR.
- Description of the documents the Agency intends to offer as exhibits at the hearing.

The hearings coordinator will provide a copy of the hearing request to Customer Services in order to maintain a log. Contents of the log are provided on a quarterly basis to the designated staff at the PIHP for recording and trending purposes.

Appellants and AHRs have the right to review the case record and obtain copies of needed documents and materials relevant to the hearing. The hearing coordinator will send a copy of the hearing summary and all documents and records to be used by the Agency at the hearing to the Appellant and AHR at least seven (7) days before the scheduled hearing.

NOTICE AND PLACE OF HEARING:

Notice of time, date and place of hearing shall be mailed to the parties or their AHR not less than ten (10) calendar days before the date of the hearing by the Tribunal. Hearings are routinely scheduled for telephone conference calls. The Administrative Law Judge conducts the hearing from his/her office. The Appellant/AHR is directed to a local CMH facility or other location as indicated on the notice. The Appellant/AHR may request permission of the Tribunal to appear by phone from another location. The request must be made to the Tribunal at least one full business day before the hearing. The Appellant/AHR may request that the hearing be conducted in person. If the Appellant/AHR requests the Administrative Law Judge (ALJ) to appear in person, the ALJ will travel to the local office or facility.

APPEARANCES:

A person may appear at the hearing on that person's own behalf or through an Authorized Hearing Representative (AHR). The Agency may appear through designated staff.

ADJOURNMENTS:

The appellant or his/her AHR may request an adjournment (also called a postponement) of a scheduled hearing. Only the Administrative Tribunal can grant or deny a request for an adjournment.

PRE-HEARING CONFERENCES:

Pre-hearing conferences with the Administrative Law Judge (ALJ) are scheduled at the discretion of the ALJ at the request of the parties or on the ALJ's own motion. The ALJ will not routinely conduct a pre-hearing conference. The Agency may offer a pre-hearing conference.

SUBPOENAS:

A subpoena may be requested when the Appellant/AHR or Agency requires:

- A person outside the agency to come to a hearing to testify; or
- A document from outside the agency to be offered as evidence in a hearing, only if not available voluntarily.

Request a subpoena by sending a memo to the Tribunal. Allow adequate time to mail or hand-deliver the subpoena. The memo must include all of the following:

- The case number
- The docket number
- The date and time the hearing is scheduled
- The name and address of the person whose testimony is required
- What document is to be subpoenaed
- Why the person's presence and/or the document is needed at the hearing
- How the person's testimony or the document relates to the hearing issue

The requestor is responsible for serving the subpoena. The Administrative Procedures Act explains when subpoenas may be issued and how subpoenas are enforced.

If the Appellant or Agency's staff responsible for presenting the hearing cannot arrange for the participation of a staff member, send a memo to the Tribunal giving:

- The name and location of the employee;
- Why the employee's participation is needed; and
- How the employee's testimony related to the hearing issue.

The Tribunal will decide whether to require the employee's participation.

THE HEARING:

The Administrative Procedures Act of 1969, as amended, applies to cases heard before the Administrative Tribunal. The Agency and Appellant will each present their positions to the ALJ, who will determine whether the actions taken are correct according to the fact, law, policy and procedure.

Following opening statements, if any, the ALJ will direct the Agency's case presenter to explain the position of the Agency. The hearing summary, or highlights of it, may be read into the record at this time. The hearing summary may be used as a guide in presenting the evidence, including the following in planning the case presentation:

- An explanation of the action(s) taken including all programs involved.
- The facts which led to the action.
- A summary of the policy or laws relied upon to take the action.
- Any clarification by the Agency's staff of the policy or laws relied upon in taking the action.

Both the Agency and the Appellant or AHR must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses, and cross-examine the author of a document offered in evidence.

The ALJ must ensure that the record is complete and may do the following:

- Take an active role in questioning of witnesses and parties
- Assist either side to be sure all the necessary information is presented on the record
- Refuse to accept evidence that the ALJ believes is unduly repetitious, immaterial, irrelevant or incompetent.

Either party may:

- State on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement; and
- Object to evidence the party believes should not be part of the hearing record.

When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and why it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides in the case being heard.

DENIAL OF REQUEST FOR HEARING:

Only the Administrative Tribunal may deny a request for a hearing. Forward all hearing requests to the Administrative Tribunal. If the Agency believes a

request is inappropriate, or, if the request was filed beyond the required deadline, do the following:

Complete a Hearing Summary stating:

- Why you believe the request should not be heard; or
- The request was received after the required deadline for filing a hearing request (attach a copy of the notice): and
- Forward the hearing request and the summary to the Tribunal.

The Tribunal will inform the Appellant, the AHR and the hearings coordinator if the request is denied. The Tribunal will deny hearing request signed by unauthorized persons and requests without original signatures.

WITHDRAWAL:

An Appellant or AHR may agree to withdraw the hearing request at any time during the hearing process. Instruct the Appellant or AHR to fill out the Request for Withdrawal of Appeal form (Exhibit K, DCH-0093) or its equivalent and return it immediately in the postage paid envelope to the Tribunal.

When any issue is still in dispute, do not:

- Suggest that the Appellant or AHR withdraw the request; or
- Mail a withdrawal form to the Appellant or AHR unless requested.

Do not ask for a withdrawal that is based on an action you plan to take in the future.

Prior to mailing the request to the Tribunal: When all issues are resolved and the Appellant or AHR wishes to withdraw the request, ask for a signed, written withdrawal. The withdrawal must clearly state why the Appellant or AHR has decided to withdraw the request. Enter all identifying case information on the withdrawal, attach the original copy to the request and forward them to the Tribunal. File a copy of the withdrawal in the case record.

After mailing the request to the Tribunal: When all issues are resolved and the Appellant or AHR wishes to withdraw the request, do the following:

- Appellant or AHR in the Agency's office: Ask for a signed, written withdrawal. Fax a copy to the Tribunal and file the original in the case record. The withdrawal must include all of the following:
    1. Program(s) in dispute
    2. Case number
    3. Tribunal register number, if known
    4. Correct address of the Appellant or AHR

- Appellant or AHR on the Telephone: Ask the caller to promptly send a signed, written withdrawal to the Tribunal.
    1. On the DCH withdrawal form, enter required identifying information and mail the form to the Appellant. NOTE: The Appellant/AHR may use some other written means to withdraw a hearing request but the Tribunal needs all the identifying information listed on the DCH form, a clear statement by the Appellant/AHR explaining his/her reason for withdrawing his/her hearing request and the signature of the Appellant or AHR.
    2. Telephone or fax the Tribunal to inform them that the request may be withdrawn. NOTE: The Agency should be available to present the case until notified by the Tribunal that the request has been dismissed.

DISMISSAL:

The Tribunal may deny or dismiss a request for a hearing if the Appellant/AHR fails to appear at a scheduled hearing without good cause.

ALJ DECISIONS:

Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.

The record must consist only of:

- The transcript or recording of testimony and exhibit or an official report containing the substance of what happened at the hearing;
- All papers and requests filed in the proceeding; and
- The recommendations or decision of the Administrative Law Judge.

The Appellant must have access to the record at a convenient place and time.

In any hearing, the decision must be a written one that:

- Summarizes the facts; and
- Identifies the regulation, policy statute, contract, or case law supporting the decision; and
- Specify the reasons for the decision; and
- Identify the supporting evidence.

The ALJ's Decision and Order is the final determination of the Department. Rehearings or reconsiderations may be granted in some circumstances. The Tribunal will send the Decision and Order to the Appellant/AHR and Hearings Coordinator. If the Decision and Order require implementation by the Agency, an Order Certification form (Exhibit M, DCH-0107) will be sent by the Administrative Tribunal with the Decision and Order to the Hearings

Coordinator. Since the Order Certification form (Exhibit M, DCH-0107) confirms the status of the Decision and Order's implementation; i.e., when the Decision and Order has or will be acted upon, it must be quickly completed and returned to the Administrative Tribunal. It is the Hearing Coordinator's responsibility to ensure that the decision is implemented within ten (10) calendar days of the Decision and Order mailing date.

Do not provide a notice of case action. The Decision and Order serve as notice of action. Complete the yellow copy of the Certification Order form within ten (10) calendar days of the mailing date on the hearing decision. Send it to the Administrative Tribunal to certify the status of implementation. Do this even when the implementation is not yet complete.

If implementation of the decision was incomplete when the yellow copy was sent to the Administrative Tribunal, fill out and mail the pink copy of the Order Certification form (Exhibit M, DCH-0107) when implementation is complete. This certifies the completion of the implementation.

REHEARING / RECONSIDERATION:

The Agency or the Appellant/AHR may file a written request for a rehearing/reconsideration. The Tribunal will grant a rehearing/reconsideration request if it meets specific criteria (see below), and there is time to rehear/reconsider the case and implement the resulting decision within the 90-day time frame. If it is not likely or possible to meet the 90-day time frame, the Tribunal will ask the Appellant to waive the timeliness requirement in writing to allow the Appellant a rehearing/reconsideration.

An Appellant's request for a rehearing/reconsideration must be sent directly to the Tribunal.

The Tribunal will grant a rehearing/reconsideration when it is believed that one of the following has occurred:

- Newly discovered evidence or evidence that should have been discovered that existed at the time of the original hearing and that could affect the outcome of the original hearing decision; or
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion; or
- A typographical, mathematical or other obvious error in the hearing decision that affects the rights of the Appellant; or
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

Agency staff must request a rehearing/reconsideration when it is believed that one of the above situations has occurred. Specify all reasons for the rehearing/reconsideration and send to the Hearing Coordinator, who will forward the request to the Tribunal.

Agency staff request for a rehearing or reconsideration must be received by the Tribunal within 30 days from the date of the Hearing Decision and Order as long as the 90-day time frame has not been exceeded.

The Administrative Tribunal will either grant or deny a rehearing/ reconsideration and send a written notice of the decision.

A rehearing is a full hearing which is granted when:

- The original hearing record is inadequate for purposes of judicial review; or
- There is newly discovered evidence that could affect the outcome of the original hearing decision.

A reconsideration is a paper review of the facts, law and any new evidence or legal arguments. It is granted when the original hearing record is adequate for purposes of judicial review and a rehearing is not necessary, but one of the parties believes the ALJ failed to accurately address all the issues.

•14•3 CLARIFICATIONS:

•14•4 CROSS-/REFERENCES:

•14•5 FORMS AND EXHIBITS:

Exhibit J – Request for Hearing (DCH-0092)
Exhibit K – Request for Withdrawal of Appeal (DCH 0093)
Exhibit L – Hearing Summary (DCH 0367)
Exhibit M – Order Certification (DCH 0107)

Administrative Approval of Procedure:	**Dated:**
[signed by Nena Sork]	May 10, 2021

•15 PROCEDURE:

MDHHS Alternative Dispute Resolution Process

•15•1 APPLICATION:

All individuals receiving services who are not Medicaid beneficiaries

•15•2 OUTLINE / NARRATIVE:

MDHHS has established this process in an effort to implement the principle that all individuals served are treated in the same manner whenever possible, inasmuch as by law, Medicaid beneficiaries are entitled to a fair hearing process with MDHHS. MDHHS is providing a choice of either a traditional review or for a mediated solution to non-Medicaid complaints.

If the Agency denies services or supports and a second opinion is requested; denies access to psychiatric inpatient services and a second opinion is requested; or takes adverse action, the Agency must notify the individual in writing of the action and their ability to access the MDHHS Alternative Dispute Resolution Process.

The Agency must also offer to assist the individual in filing a grievance with MDHHS.

Prior to using the MDHHS Grievance Process, the individual must make use of the Agency's local appeal process.

Access to the MDHHS process does not require agreement by both parties, but may be initiated solely by the individual receiving services.

The individual has ten (10) calendar days from the written notice of the Agency's local appeal process outcome in which to request access to the MDHHS Alternative Dispute Resolution Process.

MDHHS shall review all requests within two (2) business days of receipt.

If the MDHHS representative, using a "reasonable person" standard, believes that the denial, suspension, termination or reduction of services and/or supports will pose an immediate and adverse impact upon the individual's health and safety, the issue is referred within one (1) business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 3.15 of the MDHHS/CMHSP contract. This referral will be communicated by the

Department to the complainant and/or legal guardian within twenty-four (24) hours.

In all other cases, the MDHHS representative shall attempt to resolve the issue with the individual and the community mental health services program within fifteen (15) business days from the receipt of the individual's written request for review. The recommendations of the MDHHS representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual.

Requests for mediation should be made to the MDHHS and should include:

a) name of consumer
b) name of parent or legal guardian
c) phone number where person legally empowered may be reached
d) name of the community mental health services program where service is in contention
e) description of service being denied, suspended, reduced or terminated
f) description of the adverse impact to the consumer

The request (Exhibit N) should be directed to:

Department of Health and Human Services
Division of Program Development, Consultation & Contracts
Bureau of Community Mental Health Services
Attn: Request for DCH Level Dispute Resolution
Elliott-Larsen Building – 6th Floor
Lansing, MI 48913

The complainant will be contacted by an MDHHS staff person and given an opportunity to express concerns. MDHHS will consult with staff of the community mental health services program to confirm the outcome of the local appeal process. The CMH staff member will notify Customer Services upon contact by MDHHS of a pending alternative dispute resolution request. The log will be maintained and data sent on a quarterly basis to the designated staff person at the PIHP for the purpose of recording and trending.

If mediation is chosen, MDHHS staff will then gather information and schedule an informal review. Mediation will be completed within fifteen (15) business days of receipt of the complaint, providing that the disputants are able to attend a review within the time frame. The written result of the process will be completed and distributed to all participants.

•15•3 CLARIFICATIONS:

•15•4 CROSS-/REFERENCES:

•15•5 FORMS AND EXHIBITS:

Exhibit N – Request for Review by the Department of Health and Human Services