BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 1 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

Policy

It is the policy of Bay-Arenac Behavioral Health (BABH) that all consumers will have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by BABH. Procedures will be in place that ensure a timely, fair, accessible and understandable process for resolving consumer grievances and appeals based on the related Michigan Department of Community Health (MDCH) technical requirement.

Purpose

This policy and procedure is established to ensure consumers have the right to a fair and efficient process for resolving complaints regarding services and support.

Applicability

☒ All BABH Staff
☐ Selected BABH Staff, as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ BABH's (Affiliates): ☐ Policy Only ☐ Policy and Procedure

Definitions

1. Action:
   - Denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service.
   - Reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service.
   - Denial, as a whole or in part, of payment for a Medicaid or non-Medicaid covered service.

- Failure to make an authorization decision and provide notice about the decision within standard time frames.
- Failure to provide Medicaid or non-Medicaid services within standard time frame.
- Regarding Medicaid covered services, failure of the Pre-Paid Inpatient Health Plan (PIHP) to act within the time frames required for disposition of grievances and appeals.
- For a resident of a rural area, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

2. Adequate Adverse Benefit Determination – Written notice mailed or delivered at the time of the action or at the time of the signing of the individual plan of services/supports, including a statement of the action, reason for the action, regulations that support the action and explanation of the individual's right to request an evidentiary hearing.
3. Administrative Law Judge – A qualified individual designated by MDHHS to conduct a hearing in accordance with rules of evidence, Department rules, and State and Federal regulations and statutes.
4. Administrative Tribunal – A division of MDHHS that is responsible for the oversight, operations and decisions of the Administrative Law Judges carrying out their responsibility conducting Fair Hearings as required by the Michigan Mental Health Code (MMHC), Public Health Code, Social Welfare Act, Administrative Code, the Administrative Procedures Act, and/or federal law and regulation.
5. Advance Adverse Benefit Determination – Written notice that is mailed 10 calendar days in advance of the action, when previously authorized or provided services are reduced, suspended or terminated, that includes a statement of the action BABH intends to take, reason for the intended action, regulations that support the intended action, an explanation of the individual's right to request an evidentiary hearing, and an explanation of the circumstances under which services are continued if a hearing is requested.
6. Alternative Dispute Resolution Process – MDHHS dispute resolution process established to provide an administrative forum for grievances and disputes by consumers of BABHA services who are not covered by the federal standards related to Fair Hearing. If a non-Medicaid consumer is dissatisfied with a decision of BABH related to a local appeal regarding a suspension, reduction, or termination of services he/she may request this review within five (5) business days of the decision.
7. Alternative Services – A set of MDHHS – approved flexible services that are offered to beneficiaries in lieu of Medicaid state plan services, and for which Medicaid capitated funds may be used to pay under the authority of the Section (A) (1) (a) of the Social Security Act

and approved for use via Michigan's 1915 (b) waiver by the federal Centers for Medicare and Medicaid Services.

8. Appeal – A request for a review of an action (as defined above) relative to a Medicaid covered service or non-Medicaid covered service.
9. Authorized Hearing Representative – An individual who stands in for or represents the beneficiary in the hearing process. The legal right to do so comes from one of the following sources (an individual who assists, but does not stand in for the beneficiary in the hearing process does not need to meet the criteria):
    a. Written authorization, signed by the beneficiary, giving the individual authority to act for the beneficiary in the hearing process.
    b. Court appointed guardian or conservator.
    c. Legal parent of a minor child
    d. The beneficiary's spouse, or a deceased beneficiary's widow or widower, only when no one else has the authority to represent the beneficiary.
10. Consumer – For the purposes of this document, a consumer will be defined as a person receiving services, that person's authorized representative if applicable, that person's parent if he/she is a minor child, and/or guardian if applicable.
11. External Community Mediation – Process that enables people to resolve disputes by talking with one another in an informal, safe, and confidential setting conducted by a trained, neutral mediator engaged by an organization external to BABH. The mediator's goal is to assist the parties to come to a mutually agreeable resolution. The agreement reached will be non-binding.
12. Fair Hearing – An impartial review of a decision made by MDHHS or BABHA that the beneficiary believes is inappropriate. The impartial review is completed by an Administrative Law Judge.
13. Grievance – An expression of dissatisfaction about any matter relative to a Medicaid or non-Medicaid covered service, other than an action as defined above, which does not involve a rights complaint as defined below. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer.
14. Individual Plan of Service (IPOS) – A plan for treatment that includes clearly stated goals, measurable objectives and methodology that is derived from the assessment of the individual's condition, the person's wishes and desires and considering health and safety factors. This plan is developed in the context of Person and/or Family-Centered Planning.

15. Informal Resolution of Grievance or Appeal – This is a process by which the consumer may resolve grievances or appeals directly with the staff, supervisor, or administrator prior to the formal filing of a Local Appeal or Grievance. This may be initiated verbally or in writing.
16. Local Appeals Resolution Process – This is BABH's formal internal appeal and grievance resolution process as outlined in this procedure.
17. PIHP – Prepaid Inpatient Health Plan –BABH is the PIHP.
18. Primary Case Coordinator – The individual that has primary responsibility for the coordination of the consumer's services. This may be a Client Services Manager (CSM), Supports Coordinator (SC), Clinical Specialist (CS), Family Support/Respite Services Worker, Assertive Community Treatment (ACT) staff or Home-Based Services staff.
19. Residential Facility – A specialized residential, 24 hour supervised program where treatment is provided. This setting is operated under contract with BABH.
20. Utilization Review – A process, in which established criteria are used to recommend or evaluate services provided in terms of medical necessity, cost effectiveness, and effective use of resources.
21. Utilization Review Decision – The determination made as a result of a review of requested service based on severity of illness, medical necessity, cost effectiveness and effective use of resources.

Procedure

Grievance and Appeal

Values and Principles

1. Consumer's personal needs, preferences and goals are central to the Person-Centered Planning (PCP) process.
2. Disagreements which arise between consumers (and/or their legally authorized representative) and BABH staff regarding current services or treatment recommendations are natural.
3. The effectiveness of the Internal Appeals process is enhanced to the degree staff and consumers make efforts to resolve differences early and directly. Consumers will be encouraged to raise concerns with staff who are most directly involved in service planning, coordination, and provision. Staff will be sensitive to consumer disagreements and provide opportunities for open discussion of concerns.

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 5 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

4. The appeal process will include BABH supervisory staff at various levels of authority.
5. BABH staff involved in the appeal will remind the consumer and/or authorized representative of their right to file a Recipient Rights complaint if they feel their rights have been violated.
6. BABH staff will adhere to the highest standards of timeliness, fairness, and respectfulness when carrying out the appeal process.
7. Complete reports of the results of appeals will be reviewed by the appropriate administrative staff and reported in aggregate to the Performance Improvement Council to ensure the information is utilized for improving the quality of services within the organization.
8. Administrative staff may approve a non-binding external community mediation service for consumers and/or their authorized representatives who are dissatisfied with the outcome of the internal services appeal process. BABH staff will facilitate access to external advocacy services.

<u>Informal Resolution of Grievance or Appeal</u>

1. A consumer (including primary consumer, guardian if applicable, parent in the case of a minor child, and/or authorized representative if applicable) may request informal resolution of a grievance regarding their dissatisfaction with a service, disagreement with a service decision, dissatisfaction with a provider of service, service denial, reduction of a service, termination of a service, or suspension of a service. This may be requested verbally or in writing through the Member Services Representative, Program Supervisor or Service Director. The consumer will be made aware of the fact that they are not required to use this mechanism and may directly initiate the Local Appeals Resolution process.
2. The Member Services Representative, Program Supervisor, or Service Director will document the request, arrange a time to discuss the grievance or appeal with the consumer and attempt to resolve the issue. Every effort will be made to resolve the issue within seven (7) working days. The resolution will be documented in writing and forwarded to the consumer. The consumer will be notified of the formal Local Appeals Resolution process and that they may formalize the process at any point. The resolution report will be forwarded to the Recipient Rights Officer (RRO) for review and entered into the Agency grievance and appeals database.
3. If the consumer is dissatisfied (within five (5) business days of receipt of action) with the resolution of the informal disagreement and/or wishes to file a formal Grievance or Dispute, the Grievance/Dispute form (Attachment A) will be filled out and forwarded to the RRO.

BABH staff will clearly explain the Local Appeals Resolution procedure and assist the consumer in filing the appropriate form if requested.

Local Appeals Resolution Process

1. A consumer may request formal resolution of grievance or appeal regarding his/her dissatisfaction with a service, disagreement with a service decision, or dissatisfaction with a provider of service. This should be requested verbally or in writing through the Member Services Representative, RRO, Program Supervisor or Service Director. The consumer must complete the BABH Grievance/Dispute Form unless the request is for an expedited resolution. Staff will assist the consumer in filling out the form if needed, including but not limited to, interpreter services, toll-free numbers and those that have TTY/TTD and interpreter capability.
2. If the appeal is regarding an action Adverse Benefit Determination from the Agency regarding a reduction of a service, termination of a service, or suspension of a service the consumer may appeal within 45 calendar days of the action notice.
3. The RRO will log in the receipt of the Grievance or Dispute.
4. The RRO will notify any Medicaid enrollee that a Fair Hearing may be requested in lieu of or in addition to the Local Appeals Resolution process. Information will be provided regarding the process of filing a request for a Fair Hearing along with an offer to provide assistance in filing the request and an explanation of the timeframe and circumstances under which services will be continued pending the hearing decision.
5. The RRO will submit the Grievance or Appeal to the Service Director responsible for the services in dispute. If the Service Director responsible for the service was involved in the decision to suspend, reduce, or terminate the service the Grievance or Dispute will be forwarded to the supervisor of the Service Director. The formal Grievance or Appeal will be submitted to the appropriate administrative staff within two (2) calendar days.
6. The consumer will be provided with a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The consumer will be notified of the timeline for resolution and that a second opinion may be used in the appeals resolution process.
7. The consumer and his/her representative will be provided with an opportunity before and after the appeals process, to examine the consumer's case file and other relevant documents, if that is desired by the consumer.
8. The Service Director or Service Director's supervisor will facilitate a resolution to the Grievance or Dispute within ten (10) calendar days of receipt of the consumer's formal

complaint. A health care professional with appropriate clinical expertise who was not involved in the initial determination will be involved in the review and resolution. The proposed resolution will be reviewed with the Chief Executive Officer (CEO). If the issue is determined to be urgent (delay of a resolution would seriously jeopardize the health or life of the consumer), the review will be completed within three (3) working days of receipt of the appeal.

9. The RRO will monitor the resolution of the Grievance or Dispute.
10. Within three (3) working days or ten (10) business calendar days of the receipt of the Grievance or Appeal the consumer and RRO will be provided with written notice of the decision. This notice will include:
    a. The results of the resolution process and the date it was completed
    b. An explanation of the consumer's right to request a Fair Hearing or to access the MDHHS Alternative Dispute Resolution Process and an offer of assistance in filing the request. The request to access the MDHHS Alternative Dispute Resolution Process must be filed within five (5) business days of receipt of the outcome of the dispute resolution process.
    c. An explanation of the Medicaid consumers right to request to receive services while the hearing is pending, and how to make the request, including the offer of assistance. The consumer will also be informed that he/she may be held liable for the cost of those services if the hearing decision upholds the Agency's action.
    d. An explanation of the consumer's right to file a recipient rights complaint with the RRO alleging a violation of the consumer's right to treatment suited to conditions.
    e. An explanation and offer of assistance in the process of withdrawing any request for a Fair Hearing if the consumer is satisfied with the resolution of the grievance. The consumer will not be pressured to withdraw his/her request for a Fair Hearing and will be informed he/she may proceed with the Fair Hearing if that is his/her wish.
    f. An explanation and offer to set up non-binding external community mediation to resolve the Grievance or Dispute if the consumer is not satisfied with the outcome.
11. Grievance and Dispute data will be submitted to the Behavior Management Human Rights Committee (BMHRC) by the RRO for review. This data will be included in the BMHRC Standing Committee's Quarterly report to the Performance Improvement Committee. The information will be used to identify opportunities for improvement in the service delivery system.

<u>Medicaid Fair Hearing Procedure</u>

BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 8 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

1. All Medicaid beneficiaries will be informed of their right to access the Fair Hearing process. Information regarding access to the Fair Hearing process will be included in member service brochures**.** Information provided to consumers will include:

    - The right to state fair hearing
        - The method of obtaining a hearing
        - The rules that govern representation at the hearing
    - The right to file grievances and appeals
        - The requirements and time frames for filing a grievance or appeal
        - The availability of assistance in the filing process
        - The toll-free number that beneficiary can use to file a grievance or appeal by phone
    - The fact that, when requested by the beneficiary, benefits will continue if he/she files an appeal or a request for fair hearing within the time frames specified for filing; and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary.
2. The Agency shall not limit or interfere with the applicant's or consumer's right to make a request for a hearing and will assist the consumer in submitting the grievance or appeal upon request.
3. Recipients of service or service providers who assist a recipient in the grievance and dispute resolution process shall be free from discrimination or retaliation.
4. When it is determined that a covered service provided to a consumer is suspended, reduced or terminated outside the PCP process, the consumer shall be given Advance Notification (Attachment B). The Adverse Benefit Determination will be provided in the language or format needed by the individual to understand the content.
5. The Advance Adverse Benefit Determination will include:
    a. A statement of what action the Agency or contractor has taken or intends to take.
    b. The reasons for the action and the intended date of action.
    c. If access to services or hospitalization is denied, the right to request a second opinion and an explanation of the process.
    d. The specific justification that supports, or the change in Federal or State law that requires the action.
    e. An explanation of the BABH grievance resolution process, the recipient's right to request an MDHHS Fair Hearing, rights complaint process or in the case of an action based on a

change in law, the circumstances under which a hearing will be granted, along with the timeframes for doing so.

f. Regarding alternative services, the Adverse Benefit Determination must state that while alternative services are being denied, reduced, suspended or terminated, the beneficiary is still entitled to certain state plan services for which he/she has a need; and has the right to the state level arbitration process.
g. The procedure for exercising the resolution options.
h. The circumstances under which an expedited resolution is available and how to request it.
i. An explanation of the circumstances under which the Medicaid covered service(s) are to be continued if the individual files a request for a Fair Hearing, how to request that benefits be continued and the circumstances under which the consumer may be required to pay the costs of these services.

6. The primary case coordinator CSM, SC or CS will mail the Advance Notification to the consumer 12 calendar days prior to the action to ensure ten (10) calendar day advance notice.
7. The Access Department will provide Adverse Benefit Determination to the consumer when authorization or service decisions deny or limit services, within 14 calendar days of the standard request for services, or three (3) working days of the request for expedited authorization. If either of these time frames are extended at the beneficiary's or provider's request (up to an additional 14 calendar days), the Agency shall give the beneficiary written notice of the reason for the extension and inform the beneficiary of the right to file a grievance if dissatisfied with the decision to extend (adequate Adverse Benefit Determination).
8. For authorization decisions that are not made within 14 calendar days (or (3) three days for expedited authorization) and for which an extension has not been agreed to, an Adverse Benefit Determination shall be provided to the beneficiary on the 14th day (or third working day for an expedited authorization).
9. The primary case coordinator will provide adequate Adverse Benefit Determination at the time that the individual plan of service/support is signed by the consumer, his/her guardian or parent of a minor consumer.
10. The Agency may shorten the period of Advance Adverse Benefit Determination to five (5) days before the date of action if it has facts indicating that the action should be taken because of probable fraud and these facts have been verified, if possible, through secondary sources.
11. Under the following circumstances, Advance Notification will not be required, and Adequate Notification shall be issued not later than the date of the action:
    a. The Agency obtains factual information confirming the death of the consumer

b. The Agency receives a clearly written statement signed by the consumer representative that he/she no longer wishes for services; or gives information that requires termination or reduction of services and that he/she understands that this must be the result of supplying the information
c. The consumer has been admitted to an institution where he/she is ineligible under Medicaid for further services
d. The consumer's whereabouts are unknown, and the post office returns BABH's mail directed to him/her indicating no forwarding address
e. The Agency establishes the fact that the recipient has been accepted for Medicaid services by another PIHP
f. The consumer's physician prescribes a change in the level of medical care (this would include the physician's decision to discharge the consumer for a high acuity service).
g. The suspension, termination or reduction of Medicaid covered services that are prescribed/authorized by a physician, occurring within the context of the PCP process and the consumer agrees to the plan of service.

12. If the consumer receives Adverse Benefit Determination and disagrees with the action, he/she may request an informal resolution to the grievance, a formal Local Appeal Resolution with an option for obtaining a second opinion, a Recipient Rights complaint be filed and/or a MDHHS Fair Hearing. A Fair Hearing may be requested in lieu of or in addition to all the other grievance and appeal dispute options.
13. In the event a consumer requests a fair hearing before the date of action in lieu of or in addition to filing a Local Appeal, the Agency will not reduce, suspend, or terminate services until a decision is rendered after the Fair Hearing. The Agency may terminate the service prior to a decision being rendered by the Administrative Law Judge, if it is determined at the hearing that the sole issue is one of Federal or State law and the Agency promptly informs the recipient that services are to be terminated or reduced pending the MDHHS hearing decision.
14. The Agency must reinstate and continue services until a hearing decision is held if:
    a. Action was taken without the required Advance Adverse Benefit Determination; and
    b. The consumer requests a hearing within 12 calendar days of the mailing of the action and
    c. The Agency determines that the action resulted from factors other than the application of Federal or State law or policy.
15. Discontinued services will be reinstated if the consumer's whereabouts become known during the time the consumer is eligible for the services.

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 11 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

16. A consumer may request a Fair Hearing by filing out the MDHHS Hearing Request Form DCH-0092 (Attachment C). BABH staff will offer to assist the consumer in filing for a Fair Hearing if that is his/her wish.
17. The RRO will be designated as the Hearing Coordinator. An Administrator or legal counsel shall be designated by the CEO as the individual representing the Agency at the Fair Hearing.
18. The Administrative Tribunal will be responsible for notifying the Agency and consumer as to the date of the Fair Hearing.
19. The RRO will schedule the private room and ensure that all the equipment is available for the Administrative Law Judge to conduct the Fair Hearing.
20. The primary case coordinator will offer alternatives for transportation, if needed, to ensure the consumer can attend the hearing.
21. If the consumer cannot attend the Fair Hearing, he/she will be responsible for contacting the Administrative Tribunal or requesting assistance from the case coordinator to ask that the Fair Hearing be rescheduled.
22. The RRO will contact the Administrative Law Judge if it is anticipated that someone critical to the case will be late for the hearing.
23. In instances where medical issues are involved, and the Administrative Law Judge determines that a medical assessment other than that completed by the original treating physician is necessary, the Agency will be responsible for obtaining the additional assessment at its expense. The assessment will be maintained in the consumer file.
24. The assigned Administrator/Legal Counsel representing the Agency will complete a Hearing Summary Report (Attachment D). This Report and all relevant documents to be entered into evidence will be submitted to the Administrative Law Judge ten (10) days prior to the Fair Hearing date. A copy of these materials will be forwarded to the consumer prior to the Fair Hearing.
25. The Administrator/Legal Counsel representing the Agency will ensure that all witnesses relevant to the case and all documents supporting the Agency's case are available at the hearing.
26. The Administrator/Legal Counsel representing the Agency will be responsible for making the opening and closing statements representing the Agency's position, calling, and questioning the witnesses relevant to the case and ensuring that all Agency evidence is presented for consideration by the Administrative Law Judge.
27. The consumer may withdraw a request for a Fair Hearing in writing by submitting a Hearing Withdrawal Form DCH-0093 (Attachment E). BABH staff will ensure the consumer

understands that, at no point, is he/she required to withdraw his/her request for a Fair Hearing.

28. If the Agency's action is supported by the Fair Hearing decision, the Agency may seek reimbursement from the consumer for the cost of any services provided the consumer during this period of time, up to the consumer's ability to pay.
29. Adequate Adverse Benefit Determination will be provided if a service is denied; suspended, terminated or reduced if the physician determines that the consumer can be discharged from the service prior to the end of the episode of care.
30. Adequate Adverse Benefit Determination will be provided to the consumer at the time of the decision, in writing (Attachment F).
31. Adequate Adverse Benefit Determination does not require a guarantee of continuing the service if the consumer decides to request a Fair Hearing. The Agency may reinstate services if the consumer requests a Fair Hearing not more than ten (10) calendar days after the date of action.
32. If the consumer disagrees with the action, he/she may request an informal resolution, formal Internal Grievance and Dispute Resolution, Recipient Rights complaint be filed and/or an MDHHS Fair Hearing. An MDHHS Fair Hearing may be requested in lieu of or in addition to all other grievance resolution options. A Fair Hearing may also be requested if other grievance resolution options have not been satisfactory to the consumer.
33. When the consumer's IPOS is developed or modified as a result of the PCP process, Adequate Adverse Benefit Determination will be provided by the primary case coordinator through a Notice of Hearing Rights – Individual Plan of Service form (Attachment G).
34. If the primary physician determines that a service is no longer necessary and is discontinued, the primary case coordinator will provide Adequate Adverse Benefit Determination through a Denial-of-Service Letter (Attachment F).
35. If services are requested but denied through the Access Department as a result of not meeting medical necessity, severity of illness and/or intensity of service criteria, Access staff will provide Adequate Adverse Benefit Determination through a Denial-of-Service Letter.
36. The consumer may request a Fair Hearing within 90 calendar days of notice of action.
37. If a Fair Hearing is requested following Adequate Adverse Benefit Determination, the same procedure will be followed as is outlined in items 13 – 28 above (related to Advance Adverse Benefit Determination).

<u>Denial of Hospitalization</u>

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 13 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

1. If a potential consumer or active consumer is screened for high acuity services and is denied access to a psychiatric inpatient hospital any or all of the following processes may be utilized:
    a. Request a Second Opinion
        i. If the pre-admission screening unit or children's diagnostic and treatment service of the Agency denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, will be offered the option to request a second opinion from the BABH CEO.
        ii. The request for the second opinion shall be processed in compliance with Sections 409 (4), 498e (4) and 498h (5) of the MMHC. 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 CEO, in conjunction with the medical director, shall make a decision based upon all clinical information available within one business day.
    b. File a Recipient Rights Complaint
        i. If the request for a second opinion itself is denied, the individual or someone on his/her behalf may file a rights complaint with the Agency's Office of Recipient Rights (ORR) for processing under Chapter 7A.
        ii. If the initial request for inpatient admission is denied, and the individual is a current recipient of other Agency services, the individual or someone on his/her behalf, may file a rights complaint alleging a violation of his/her right to treatment suited to condition.
        iii. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current recipient of other Agency services, and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the Agency's ORR for processing under Chapter 7A.
    c. Appeal (see Local Appeals Resolution section)
    d. MDHHS Level
        i. Medicaid Fair Hearing (see Fair Hearing process section): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
        ii. MDHHS Alternative Dispute Resolution (see this section): for appeals on actions that impact non-Medicaid covered services.

2. If a second opinion is requested, the CEO or his/her designee will be responsible for arranging for an evaluation by a psychiatrist, other physician, or licensed psychologist within 3 days, excluding Sundays and legal holidays.
3. If an individual is assessed and found not to be clinically appropriate for inpatient psychiatric hospitalization, the Emergency Services Department will provide appropriate referral service if that was not accomplished after the initial preadmission screening.

Denial of Access to any Services for Individuals not Receiving any Agency Services

1. Any or all of the following processes may be utilized:
    a. Request for a Second Opinion – If an initial applicant for mental health services is denied such services by the Agency, the applicant or his/her guardian, or the applicant's parent in the case of a minor shall be informed of their right to request a second opinion of the CEO. The request shall be processed in compliance with Section 705 of the MMHC and will be resolved within five (5 (business days.
    b. Rights Complaint – The applicant or his/her guardian may not file a recipient rights complaint for denial of services suited to condition as he/she does not have standing as a recipient of mental health services. Recipient Rights may be used to assist the consumer in completing the BABH Grievance/Dispute Form. The applicant or his/her guardian may, however, file a rights complaint if the request for a second opinion is denied by the Agency.
    c. Appeal – See Local Appeals Resolution process section.
    d. MDHHS Level
        i. Medicaid Fair Hearing (see Fair Hearing process section): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
        ii. MDHHS Alternative Dispute Resolution (see this section): for appeals on actions that impact non-Medicaid covered services.
        iii. State level arbitration for alternative services (per current MDHHS Appeal and Grievance Resolution Processes Technical Requirement)

Denial through the Service Authorization Process of the Request for Medicaid State Plan, Waiver or Alternative Service, or Denial of the Requested Amount, Scope or Duration of a Service that was Identified and Agreed upon by the Beneficiary during Person-Centered Planning

1. Any or all of the following processes may be utilized:
    a. Rights Complaint

b. Appeal – See the Local Appeals Resolution process section
c. MDHHS Level
    i. Medicaid Fair Hearing (see Fair Hearing process section): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
    ii. MDHHS Alternative Dispute Resolution (see this section): for appeals on actions that impact non-Medicaid covered services.
    iii. State level arbitration for alternative services (per current MDHHS Appeal and Grievance Resolution Processes Technical Requirement)

<u>Unreasonable Delay of a Medicaid State Plan, Waiver, or Alternative Service Beyond the Start Date Agreed Upon During Person-Centered-Planning and as Authorized by the Agency - Unreasonable Delay is defined as 14 or More Calendar Days</u>

1. Any or all the following processes may be utilized
    a. Rights Complaint
    b. Appeal – See the Local Appeals Resolution process section
    c. MDHHS Level
        i. Medicaid Fair Hearing (see Fair Hearing process section): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
        ii. MDHHS Alternative Dispute Resolution (see this section): for appeals on actions that impact non-Medicaid covered services.
        iii. State level arbitration for alternative services (per current MDHHS Appeal and Grievance Resolution Processes Technical Requirement.

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 16 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

Suspension, Reduction or Termination of a Current Medicaid State Plan, Waiver, or Alternative Service

1. Any or all the following processes may be utilized
    a. Rights Complaint
    b. Appeal – See the Local Appeals Resolution process section
    c. MDHHS Level
        i. Medicaid Fair Hearing (see Fair Hearing process section): for Medicaid beneficiary appeals on actions that impact Medicaid covered services.
        ii. MDHHS Alternative Dispute Resolution (see this section): for appeals on actions that impact non-Medicaid covered services.
        iii. State level arbitration for alternative services (per current MDHHS Appeal and Grievance Resolution Processes Technical Requirement.

Dissatisfaction About Any Matter Relative to a Medicaid State Plan, Waiver or Alternative Service other than an Action as Described Above

Any or all the following processes may be utilized:

a. Grievance – See Informal Resolution of Grievance or Appeal section. Possible subjects include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a provider and the consumer.
b. Rights Complaint – Statements or allegations, verbal or written, by the consumer or anyone acting on his/her behalf that alleged a violation of an MMHC protected right cited in Chapter 7 will be resolved through processes established in Chapter 7A.

MDHHS Alternative Dispute Resolution Process for Persons Not Receiving Medicaid Services

1. The notice of Local Appeal Resolution decision or Second Opinion Action Notice (Attachment H) to a person, who does not have Medicaid, will include information on the consumer's right to request access to the MDHHS Alternative Dispute Resolution process. This notice will also include information regarding the consumer's right to file a Recipient Rights Complaint with the RRO, alleging a violation of the recipient's right to treatment suited to his/her condition. This action may be initiated solely by the consumer. BABH staff will assist the consumer to access this process if he/she requests that.
2. Consumers interested in accessing the Alternative Dispute Resolution Process must request a review in writing (Request for Review Form, Attachment I), within five (5) business days of the written outcome of the Local Appeal Resolution or Second Opinion. The request must include the following:

a. Name of CMHSP recipient
b. Name of Guardian legally empowered to make treatment decisions or parent of minor child
c. Daytime phone number where the consumer, guardian legally empowered to make treatment decisions, or parent of a minor child may be reached
d. Name of the Agency/Program 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

3. The CEO will appoint a supervisor or Service Director to work with an MDHHS representative from the Division of Program Development, Consultation and Contracts, to complete the Alternative Dispute Resolution process.
4. The MDHHS representative will refer the dispute to the appropriate MDHHS Bureau of Community Mental Health Services representative for contractual action within one (1) business day if 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. Contractual Action will be taken consistent with the applicable provisions of the MDHHS/CMHSP contract. This referral will be communicated in writing to the consumer, guardian, or parent of a minor child within 24 hours.
5. The assigned MDHHS representative will complete his/her review within 15 business days in cases that do not pose an immediate danger to the individual's health and/or safety. Written notice of the resolution shall be submitted to the consumer, his/her guardian or parent of a minor recipient.
6. BABH will maintain a record of appeals and grievances and their disposition that is available for review by staff of the State of Michigan.

<u>Denial or Termination of Family Support Subsidy</u>

1. BABH staff will review all applications for the Family Support Subsidy and promptly approve or deny the application.
2. BABH staff will provide written notice to the applicant of the action and the right of the parent or guardian to administratively appeal the decision if it is adverse.
3. If the application is denied due to insufficient information on the application form or the required attachments, BABH staff shall identify the insufficiency in the written notification.

4. If an application for a Family Support Subsidy is denied or terminated by BABH, the parent or legal guardian will be informed of his/her right to request a hearing.
5. The request for hearing must be submitted in writing within two (2) months of the Adverse Benefit Determination of termination or denial and addressed to the CEO. If assistance with this request is desired and requested, BABH staff will provide it.
6. The hearing will 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, being sections 24.271 to 24.287 of the Michigan Compiled Laws.

State Level Arbitration Process for Disputes About Alternative Services

1. BABH follows the current MDHHS process included in the Appeal and Grievance Resolution Processes Technical Requirement related to this subject.

Attachments

A. Grievance/Dispute Form
B. Advance Action Adverse Benefit Determination – Medicaid
C. MDHHS Hearing Request Form – DCH-0092
D. Hearing Summary Report – Outline
E. MDHHS Hearing Request Withdrawal Form – DCH-0093
F. Adequate Action Adverse Benefit Determination – Denial of Service
G. Notice of Hearing Rights – Individual Plan of Service
H. Grievance/Dispute Action Adverse Benefit Determination – Non-Medicaid
I. Request for Review
J. Treatment Rights for Consumers Seeking Voluntary Admission
K. Treatment Rights for Consumers who Require Involuntary Admission

Related Forms

N/A

Related Materials

N/A

BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

Chapter: 3	**Member Rights and Responsibilities**		
Section: 3	**Rights of Consumers**		
Topic: 12	**Grievance and Appeal**		
Page: 19 of 19	**Supersedes Date:** **Pol:3-18-99** **Proc: 1-20-04, 3-11-03, 3-18-99** **[11-19-99 (04-07-22)]**	**Approval Date:** **Pol: 10-16-03** **Proc: 6-15-04**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 3/13/2025. For Controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

References/Legal Authority

1. Appeal and Grievance Resolution Processes Technical Requirement (Revised August 2003)
2. PA 516 of 1996
3. PA 258 of 1974, as amended
4. S.353-Health Insurance Bill of Rights of 1997
5. 42 CFR Chapter IV, Subpart E, Sections 431.200 et seq
6. 42 CFR Chapter IV, Subpart F, Sections 438.402 to 424
7. MDCH-MSA Policy Bulletin: Medicaid Eligibility Manual – Beneficiary Hearings
8. MDCH-MSA Policy Bulletin: Hourly Home Care – Criteria for Determining Number of Hours (Children's Waiver)

SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
Wolber	L. Maze	11/10/2009		
M. Prusi	C. Pinter		Revision	Annual and Triennial Review – Revisions to update agency acronyms and terminology.
Prusi-Melissa	C. Pinter	1/6/2021	No changes	Annual review
Prusi-Melissa	C. Pinter	6/23/2021	No changes	Triennial Review
M. Prusi	C. Pinter	09/27/2024	No changes	Triennial Review