HIAWATHA BEHAVIORAL HEALTH
Administrative Policy

CHAPTER: Program Administration	SECTION: Consumer Notice and Appeal/Consumer Grievance/Dispute Resolution Process – 5.6
EFFECTIVE DATE: 3/15/10	APPROVAL /REVISED DATE: 5/23/16
REVIEW DATE: 5/4/16	REVIEW COMMITTEE: Program/Planning Changes: Yes: __X___ No: _____

I. Purpose

The purpose of this policy is to outline the Notice/appeal grievance and dispute processes for persons served of services provided by Hiawatha Behavioral Health hereafter referred to as HBH. This is a three layered system with persons served rights protected by local, state and federal laws and regulations. The resolution of person served concerns and the goal of improving quality of care are key aspects of these processes. We will follow MDHHS contract attachment P.6.3.1.1

II. Policy

It is the policy of Hiawatha Behavioral Health that all persons served have the right to a fair and efficient process for resolving disagreements regarding their services and supports. A person served of, or applicant for, public mental health services may access several options to pursue the resolution of disagreements. Persons served will be informed of these rights from the time of the initial application for services and throughout their treatment at HBH. Persons served will be educated as to the basic information about their appeal and grievance rights; how to initiate the processes; and will be provided assistance in completing forms and in taking procedural steps if requested and/or needed. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.

III. Definitions

A. Action

1. The denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service
2. The reduction, suspension, or termination of a previously authorized Medicaid or non-Medicaid covered service;
3. Denial in whole, or in part, of payment for a Medicaid or non-Medicaid service;
4. The failure of HBH to make an authorization decision and provide notice about the decision within the standard time frames;
5. The failure of HBH to make an expedited authorization decision with three (3) working days from the date of receipt of a request for expedited service authorization (Medicaid person served);
6. The failure of HBH to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized;

7. The failure of HBH to act within 45 calendar days from the date of a request for a standard appeal;
8. The failure of HBH to act within three (3) working days from the date of a request for an expedited appeal;
9. The failure of HBH to provide disposition and notice of a local grievance within 60 calendar days of the date of the request.

B. **Adequate Notice:** A written notice mailed or directly provided to a consumer or his/her guardian or legal representative at the same time an action takes effect or at the time of signing of the Individual Plan of Service (IPOS).
C. **Advance Notice**: A written notice that is provided to the person served or his/her guardian or legal representative at least twelve (12) calendar days before the date of action involving a termination, suspension or reduction of a service currently in the approved treatment plan.
D. **Alternative Services:** Services offered under authority of Section 1915(a)(1)(A), Michigan's1915(b) Specialty Services Waiver and the services covered under the 1915(c) Habilitation Supports Waiver. These services may be offered by HBH to allow a wider, more flexible and mutually negotiated set of supports and services than possible with the State Plan Services. The list of Alternative Services is in the MDHHS master contract with NorthCare and will become part of Michigan Medicaid Manual, Chapter III.
E. **Appeal**: A request for a review of an action (as defined above) relative to a Medicaid covered service or non-Medicaid covered service.
F. **Authorized Representative**: The person the person served selects to represent them during the Grievance and Appeal process.
G. **Chief Executive Officer (CEO):** CEO of NorthCare or the CEO of an Affiliate, or the CEO's designee.
H. **Hearing Officer:** Person or his/her designee appointed by the CEO to coordinate the Administrative Hearing process.
I. **Grievance:** An expression of dissatisfaction about any matter other than an action as defined above
J. **Michigan Department of Health & Human Services (MDHHS) Administrative Hearing:** An evidentiary hearing conducted by an Administrative Law Judge with the MDHHS Administrative Tribunal regarding a decision by NorthCare or HBH to deny, terminate, reduce or suspend a Medicaid covered service or a Habilitation Supports Waiver Service.
K. **Michigan Department of Health & Human Services (MDHHS) Alternative Dispute Resolution Process:** An impartial review, conducted by a MDHHS representative, regarding a decision by NorthCare or HBH to deny, terminate, reduce or suspend a non-Medicaid covered service.
L. **NorthCare Network**: Michigan Upper Peninsula Prepaid Health Plan for behavioral health Medicaid services – persons with severe mental illness, children (and families) with serious emotional disturbance and persons with developmental disabilities.
M. **Resolution Notice**: Notice to the person served that is required within established time frames relative to the acknowledgment of receipt of appeal and the disposition of grievances and resolution of appeals.

N. **Rights Complaint:** A written or verbal statement by a person served or anyone acting on behalf of a person served alleging a violation of a protected right cited in Chapter 7 of the Mental Health Code, which is resolved through the processes established in Chapter 7A.
O. **State Plan Services:** Services that NorthCare Providers are required to offer according to the Michigan Medicaid Provider Manual.
P. **Utilization Review:** A process, in addition to the IPOS, in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity and effective use of resources.

IV. Procedures

A Medicaid person served has the right to file a Local Appeal and/or a Fair Hearing Request whenever a Medicaid covered service is denied. A non-Medicaid person served may file a Local Appeal and then a request for MDHHS Alternative Dispute Resolution following the Local Appeal.

A. Notice Requirements
   1. Notice is given whenever a Medicaid State Plan, waiver, alternative service or general fund mental health service is denied, reduced, suspended or terminated. This notice must be in writing and must be provided in the language format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency.)

Action	Type of Notice	Time Frame for Notice
Denial of service request	Adequate/Denial of service	at the time of decision
Plan of Service developed	Adequate	at the time of plan development
Increase in benefits	Adequate	at the time of the action
Reduction, suspension or termination of service currently being received	Advance	12 days before action
Standard authorization decision that denies or limits services requested	Adequate	within 14 days of request*
Expedited authorization decision that denies or limits services requested	Adequate	within 3 working days of request*

*Time frames may be extended up to another 14 days at the request of the consumer or the provider
Note: If a consumer's physician makes a determination that a particular Medicaid State Plan or Waiver service is not medically necessary, no adverse action occurred and an advance notice is not required.

   2. The written notice (as defined above) must contain the following:
      a. The action the PIHP/CMHSP or its contractor has taken or intends to take.
      b. The reasons for the action.
      c. The date of the intended action.
      d. If access to services or hospitalization is denied, the right to request a second opinion and an explanation of the process.

e. Persons Served with Medicaid have the right to file a Fair Hearing Request and/or a Right's Complaint.–(the latter is relative only to the suspension, reduction or termination of a service or the denial of hospitalization) and the time frames for doing so.
f. The procedures for exercising the resolution options
g. The circumstances under which expedited resolution is available and how to request it.
h. In regard to Medicaid covered services, the person's served right to have benefits, in a current Individual Plan of Service (IPOS), continue pending resolution of the appeal or MDHHS Fair Hearing decision, how to request that benefits be continued, and the circumstances under which the person served may be required to pay the costs of these services.
i. Clinical rationale of decision upon request by the person served

3. Adequate Notice (Applies to all persons served)
   a. During the person-centered planning process adequate notice will be provided at the time the (IPOS), developed or modified through a person-centered planning process, is finalized with the person served or his/her guardian or authorized representative.
   b. Denial of Service outside the PCP Process (Applies to all individuals.)
   When an individual is denied initial access to services, denied for a request for more services or new services, or denied access to a person served requested inpatient psychiatric hospitalization, the individual will be informed of this denial with an adequate notice. The form may be presented directly or mailed to the individual or his/her guardian or authorized representative at the time of denial. A Medicaid enrolled person served has the right to file a fair hearing request whenever a Medicaid covered service~~s~~ is denied. A non-Medicaid person served may file an appeal using the local appeal procedure described below.
   c. Persons served who are beneficiaries of Medicaid will receive notification by the Medicaid Adequate Notice of Action For Mental Health Services form. Persons served who do not receive Medicaid benefits will receive notification by the Adequate Notice of Action for Non-Medicaid Consumer form.
4. Advance Notice (applies to all persons served)
   a. Whenever Medicaid State Plan or Waiver services are denied, suspended, reduced, or terminated as a result of a Utilization Review or authorization function or administrative function, for a current IPOS, HBH will issue an Advance Notice of Adverse Action to the person served
   b. An Advance Notice will be mailed at least twelve (12) calendar days before the date of action.
   c. Persons served who are beneficiaries of Medicaid will receive notification by the Medicaid Advance Notice of Action for Mental Health Services form. Persons served who do not receive Medicaid benefits will receive notification by the Advance Notice of Action for Non-Medicaid Consumer form.
   d. Exceptions to the Advance Notice. HBH will not give Advance Notice if:
      - It has factual information confirming the death of the person served;
      - It receives clear written documentation that:

- The person served has been admitted to an institution where he/she is ineligible under Medicaid for further services;
  The person served whereabouts are unknown and the post office returns to NorthCare/ HBH mail directed to him/her indicating no forwarding address;
  - A change in the level of medical care is prescribed by the person's served physician.
  - NorthCare/HBH may shorten the period of advance notice 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.

5. Documentation of all Notices provided will be maintained in the EMR

V. GRIEVANCE AND APPEAL RESOLUTION PROCESSES

An individual receiving mental health specialty services and supports may pursue appeals or grievances using multiple options simultaneously. Medicaid persons served are not required to exhaust local processes before they request a Medicaid Fair Hearing.

A. Denial of Hospitalization
   1. Request for second opinion
      a. If a preadmission screening unit or children's diagnostic and treatment service of HBH denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, may request a second opinion from the CEO of HBH
      b. The CEO shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within three (3) days, excluding Sundays and legal holidays, after the CEO receives the request. If the determination of the second opinion is different from the determination of the preadmission screening unit, the CEO, in conjunction with the Medical Director, shall make a decision based on all clinical information available within one (1) business day**.**
      c. The CEO'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 CEO and Medical Director or verification that the decision was made in conjunction with the Medical Director.
      d. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide appropriate referral services.
   2. Rights Complaint
      a. If the request for a second opinion is denied, the individual or someone on his/her behalf may file a recipient rights complaint with the Recipient Rights Office of HBH.
      b. If the initial request for inpatient admission is denied and the individual is a current person served of other HBH services, the individual or someone on his/her behalf is informed that they may file a recipient rights complaint with

the Recipient Rights Office alleging a violation of his/her right to treatment suited to condition.

c. If the second opinion determines the individual is not clinically suited for Hospitalization and the individual is a current person served of other HBH 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 Recipient Rights Office of HBH.

3. Appeal
   See Local Appeal Resolution Process section.
4. MDHHS Level
   a. If the person served is a Medicaid consumer see Medicaid Consumer Rights to Administrative hearing section.
   b. If the person served is not a Medicaid consumer see MDHHS Alternative Dispute Resolution Process section.

B. Denial of Access to Community Mental Health Program Services
   If an applicant for HBH services is denied such services, an appropriate referral may be provided.
   1. Request for Second Opinion
      a. If an initial applicant for HBH services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor, must be informed of their right to request a second opinion of the CEO or designee. The request shall be processed in compliance with Section 705 of the Michigan Mental Health Code and must be resolved within 45 calendar days.
      b. The CEO or designee shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker or master's level psychologist.
      c. If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or a developmental disability, and meets the medical necessity criteria, or is experiencing an emergency situation or urgent situation, the community mental health services program shall direct services to the applicant.
   2. 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 person served of mental health services. The applicant or his/her guardian may, however, file a rights complaint if their request to receive a second opinion is denied.
   3. Appeal
      See Local Appeal Resolution Process section
   4. MDHHS Level
      a. If the person served is a Medicaid enrolled person served, see Medicaid Consumer Rights to Administrative Hearing section
      b. If the person served is not a Medicaid enrolled person served see MDHHS Alternative Dispute Resolution Process section.

C. Denial through the service authorization process of the request for Medicaid state plan, waiver, alternative service, or general fund mental health service OR denial of

the requested amount, scope or duration of a service that was identified and agreed upon by the person served during person-centered planning

1. Appeal --See Local Appeal Resolution Process section.
2. Rights Complaint
    a. The person served or his/her guardian may file a rights complaint for treatment suited to condition.
3. MDHHS level
    a. Medicaid Consumer Rights to Administrative Hearing.
    b. MDHHS Alternative Dispute Resolution for non-Medicaid covered services

D. Unreasonable delay of a Medicaid state plan, waiver, alternative service, or general fund mental health service beyond the start date agreed upon during the person-centered planning process and as authorized by HBH. Unreasonable delay is defined as 14 or more calendar days.
    1. Appeal ---See Local Appeal Resolution Process section.
    2. Rights Complaint
        a. The person served or his/her guardian may file a rights complaint for treatment suited to condition.

E. Denial or Termination of Family Support Subsidy
    1. Pursuant to Section 159(3) of the Code: "If an application for a family support subsidy is denied or a family support subsidy is terminated by HBH, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by HBH. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws."
    2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from HBH. (R330.1616 Availability of Forms) (NOTE: It is acceptable to ask families to write a letter to HBH requesting an appeals hearing in lieu of a standardized form.)
    3. HBH 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 is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, HBH shall identify the insufficiency. (Rule R330.1641 Application Review)
    4. If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to HBH within two (2) months of the notice of denial or termination. (R330.1643 Appeal)
        - First Appeal: Hiawatha Behavioral Health, 3865 S. Mackinac Trail, Sault Ste. Marie, MI 49783
        - Final Appeal: Family Support Subsidy Program, Attn: Appeals, Michigan Department of Health and Human Services, Lewis Cass Bldg. 5th Floor, 320 S. Walnut Street, Lansing, MI 48913
    5. If the MDHHS representative, using a "reasonable person" standard, believes that the denial or termination of the subsidy will pose an immediate and adverse

impact upon the person's served health and safety, the issue is to be referred within one business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDHHS/CMHSP contract.

VI. DISPUTE RESOLUTION DURING THE PCP PROCESS

A. If an individual requests inpatient treatment, or a specific mental health support or service for which appropriate alternatives for the individual exist that are of equal or greater effectiveness and equal or lower cost, the staff should:
   1. Identify and discuss the underlying reasons for the request/preference;
   2. Identify and discuss alternatives with the individual; and
   3. Negotiate toward a mutually acceptable support, service and/or treatment.

B. In the event that a mutually acceptable alternative cannot be reached, the staff should:
   1. Document the individual's preference, the support, service and/or treatment offered and the reason for not accepting that preference.
   2. Inform the individual of their right to file a grievance or local appeal. This would include:
      a. His/her right to contact the Recipient Rights Office/Customer Services Office and file a grievance for investigation, consultation, mediation or intervention in response to their request for a specific mental health support or service.
      b. His/her right to request a second opinion as referenced in the Mental Health Code, and his/her right to a Fair Hearing, if a consumer with Medicaid coverage.

C. If in the judgment of staff, an individual's choice or preference for the inclusion or exclusion of a planning participant, meeting location, or specific provider poses an issue of health or safety or exceeds reasonable expectations of resource allocation, staff should discuss and identify the individual's underlying reason for that specific choice or preference. Then, negotiate toward a mutually acceptable alternative that meets the outcomes intended.

D. If an individual is not satisfied with his/her Individual Plan of Service, the Michigan Mental Health Code allows the individual to make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within thirty (30) calendar days.

E. If the individual believes that the opportunity for person-centered planning is not provided as specified in the manner above, it is the responsibility of HBH to inform the individual of his/her right to file a complaint with the Recipient Rights Office/ Customer Services Office at HBH.

F. When there is a disagreement between an individual and the legal guardian or responsible parent, staff should attempt to mediate between the two parties in order to provide an outcome that is acceptable to both parties.

G. During the person-centered planning process Adequate Notice (applies to all consumers) will be provided at the time the Individual Plan of Service is finalized with the person served and/or his/her guardian or authorized representative. Notice will include:
   1. Basic information as to appeal rights and what options exist to resolve service

delivery disputes;
2. Information regarding how to access services, obtain help with problems, and how to inquire about benefits.

VII. GRIEVANCE PROCEDURE (APPLIES TO ALL INDIVIDUALS)

A. At any time, a person served or his/her legal representative may express their dissatisfaction by filing a grievance. The grievance process would be utilized when a concern is not addressed either through a formal "Action" process or through a "rights complaint" as outlined in the Michigan Mental Health Code. A person served may file a grievance either in writing or orally with HBH Recipient Rights Office and/or the Customer Services Office. Upon receipt of a grievance, the Recipient Rights Office/ Customer Services Office shall:
   1. Determine whether the grievance is more appropriately a recipient rights complaint, and if so, refer the grievance, with the person's served permission, to the Office of Recipient Rights;
   2. Log receipt in the NorthCare Recipient Rights Complaint and Appeals/Customer Service Database;
   3. Send an acknowledgment letter within five (5) business days of receipt;
   4. Submit the grievance to the appropriate staff including a HBH administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination. Facilitate resolution of the grievance within thirty (30) calendar days of receipt of the grievance but may take up to sixty (60) days if needed according to MDHHS P.6.3.1.1. If a grievance takes longer than sixty (60) calendars days a Notice for Appeal must be given.

VIII. LOCAL APPEAL PROCEDURE FOR CONSUMERS WITH MEDICAID

A. Appeal Process: Within forty-five (45) calendar days of the Notice of Action (either Advance or Adequate), the person served or his/her legal representative, may file a Local Appeal either orally or in writing with the HBH Recipient Rights Office. Unless the person served is requesting an expedited appeal, the person served must confirm an oral appeal request with a written signed request.
   1. The Office of Recipient Rights shall then:
      a. Log receipt of the Local Appeal request in the HBH and NorthCare Recipient Rights Appeal Database and send an acknowledgement letter within ten (10) business days of receipt of the Local Appeal request.
      b. Advise the individual, guardian, or in the case of a minor, the parent, that he/she may file a request for a MDHHS administrative hearing in lieu of or in addition to the Local Appeal. This information provided to the individual shall include the process for filing the request for a hearing, an offer of assistance in filing the request, and an explanation of time frames and circumstances under which services will be continued pending the hearing decision.
      c. Submit the Local Appeal to the appropriate staff with the authority to require corrective action; none of whom may have been involved in the initial

determination to deny, suspend, terminate, or reduce the service.

2. HBH will provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. If the appellant has requested an expedited resolution, staff shall inform the appellant of the limited time available to present evidence.
3. Provide, if requested by, the appellant or his/her representative opportunity, before and during the appeals process, to examine the appellant's case file including medical records, and any other documents and records considered during the appeals process.
4. Facilitate resolution of the appeal within ten (10) calendar days of receipt; assure an expedited review of a local appeal involving an emergent situation where the standard ten (10) day time frame would seriously jeopardize the health or life of the individual. Such a review shall be completed within 24 hours of receiving all necessary information by relevant HBH services staff involved in the local appeal process.

B. Resolution of the Appeal: HBH will provide as expeditiously as the person's served health condition requires, but not to exceed 45 calendar days, to the individual, guardian, or parent of a minor child or his/her legal representative, written notification of the resolution in regard to the Local Appeal. For an expedited appeal HBH must make reasonable efforts to provide oral notice and follow-up with written notice. The written notice shall include:
   1. The results of the appeal and the date completed;
   2. An explanation of the right to request an MDHHS Administrative Fair Hearing and an offer of assistance in filing the request;
   3. The right to receive benefits while a requested hearing is pending and that the consumer may be held liable for the cost of those benefits if the hearing decision upholds the decision of HBH's action;
   4. For appeals resolved not wholly in favor of a person served who is disputing action that impacts a non-Medicaid covered service, information on how to file for a MDHHS Alternative Dispute Resolution and an offer of assistance;
   5. For appeals resolved locally to the satisfaction of the person served an explanation and offer of assistance in the process for withdrawing a Fair Hearing request;
   6. Information on the right to file a Recipient Rights complaint with the Recipients Rights Office alleging a violation of the person's served rights to treatment suited to his/her condition.
   7. HBH may extend timeframes for a local appeal by up to fourteen days if:
      a. The person served requests the extension;
      b. HBH must document there is a need for additional information and how it is in the person's served best interest. This documentation must be made to MDHHS upon request.

IX. LOCAL APPEAL PROCEDURE FOR PERSONS WITHOUT MEDICAID

A. Appeal Process: Within forty-five (45) calendar days of the Notice of Action (either Advance or Adequate), the person served or his/her legal representative, may file a Local Appeal either orally, or in writing with the HBH Recipient Rights Office.

Unless the person served is requesting an expedited appeal, the person served must confirm an oral appeal request with a written signed request.

1. The Recipient Rights Office shall then:
    a. Log receipt of the local appeal request in the HBH and NorthCare Member Services Appeals Database and send an acknowledgement letter to the appellant within ten (10) business days of receipt of the request.
    b. Submit the Local Appeal to the appropriate staff with the authority to require corrective action; none of whom shall have been involved in the initial determination.
2. HBH will provide the appellant a reasonable opportunity to present evidence and allegations of fact or law orally, as well as in writing. If the appellant has requested an expedited resolution, staff shall inform the appellant of the limited time available to present evidence
3. Provide, if requested by, the appellant or his/her representative opportunity, before and during the appeals process, to examine the appellant's case file including medical records, and any other documents and records considered during the appeals process.
4. Facilitate resolution of the appeal within ten (10) calendar days of receipt.
5. Assure an expedited review of the appeal involving an emergent situation where the standard ten (10) day time frame would seriously jeopardize the individual's health or safety. Such a review shall be completed within 24 hours of receipt of all necessary information by relevant HBH Services staff involved in the local appeal process.

B. Resolution of the Appeal: HBH will provide as expeditiously as the person's served health condition requires, but not to exceed 45 calendar days, to the individual, guardian, or parent of a minor child or his/her legal representative, written notification of the decision resolution in regard to the Local Appeal. For an expedited appeal HBH must make reasonable efforts to provide oral notice. The written notice shall also include:
    1. The results of the appeal and the date completed.
    2. Information regarding the individual, guardian, or parent of a minor child's right to access the MDHHS Alternative Dispute Resolution Process and an offer of assistance in doing this;
    3. Information on the individual, guardian, or parent of a minor child or his/her legal representative's right to file a recipient rights complaint with the Recipient Rights Office alleging a violation of the consumer's rights to treatment suited to his/her condition.

X. MDHHS ALTERNATIVE DISPUTE RESOLUTION PROCESS FOR PERSONS SERVED WITHOUT MEDICAID

A. Within ten (10) business days after receiving Notice of the decision reached during the local appeal process, the person served or his/her authorized representative may request access to the MDHHS Alternative Dispute Resolution process. Access to this process does not require agreement by HBH and may be initiated solely by the consumer.

B. Requests may be received in any written form, but must include the following information:
   1. Name of the HBH person served;
   2. Name of the guardian legally empowered to make treatment decisions or a parent of a minor child;
   3. Daytime phone number where the person served, legal guardian, or parent of a minor child may be reached;
   4. Name of the CMHSP where services have been denied, suspended, reduced or terminated;
   5. Description of the service being denied, suspended, reduced, or terminated;
   6. Description of the adverse impact on the consumer caused by the denial, suspension, reduction or termination of service.
   7. The request should be directed to:
      - MI Department of Health and Human Services
        Division of Program Development, Consultation and Contracts
        ATTN: Request for MDHHS Alternative Dispute Resolution
        Lewis Cass Building 5th Floor
        Lansing, MI 48913

C. HBH communications to persons served regarding this Alternative Dispute Resolution Process shall include the information contained in item B above. HBH will inform MDHHS of the potential Dispute Resolution along with the information on the original appeal and reasons for upholding the denial.

D. If the MDHHS representative, using a "reasonable person" standard, believes that the denial, suspension, termination or reduction of the services and/or supports will pose an immediate and adverse impact upon the person's served health and safety, the issue is to be referred within one (1) business day to the Bureau of Community Mental Health Services for contractual action consistent with applicable provisions of the MDHHS/ HBH contract. In all other cases, MDHHS shall complete its review of the dispute within fifteen (15) business days of receipt. Written Notice of the resolution shall be submitted to the person served, his/her guardian or parent of a minor person served.

E. The Office of Recipient Rights will:
   1. Provide information about the process for filing;
   2. Offer to assist the individual with filing;
   3. On the day the request for Alternative Dispute Resolution is received:
      a. Date stamp the request
      b. Fax the request to MDHHS
      c. Mail the request to MDHHS
      d. Log the request in the NorthCare Database
      e. Forward a copy of the request to the Hearings Officer

XI. MEDICAID ENROLLED PERSON'S SERVE RIGHT TO ADMINISTRATIVE HEARING

A. All Medicaid enrolled persons served are told of their right to an Administrative Fair Hearing if they are dissatisfied at any point with their treatment plan.

B. MDHHS Administrative Fair Hearing
   1. Within ninety (90) calendar days after receiving notice that Medicaid State Plan, Alternative Services or Waiver services have been denied, suspended, reduced, or terminated, a Medicaid consumer or his/her authorized representative may:
      a. Request an Administrative Fair Hearing directly with the MDHHS;
      b. Request a local Appeal;
      c. File a rights complaint with the HBH Recipient Rights Office for failure to provide treatment suited to condition;
      d. Simultaneously file a request for a local appeal with the HBH Recipient Rights Office, and file a request for an Administrative Fair Hearing with MDHHS and file a rights complaint.
   2. The Office of Recipient Rights will:
      a. Provide information about the process for filing, the time frames, the circumstances when services will be continued until a hearing decision is rendered, and the process for withdrawing a hearing request;
      b. Offer to assist the individual with filing a hearing request;
      c. On the day the hearing request is received:
         - Date stamp the request;
         - Fax the request to MDHHS;
         - Mail the request to MDHHS;
         - Forward a copy of the request to be logged;
         - Log the Request in the HBH and the NorthCare Customer Services Grievance Database.
      d. Receive notice of hearing requests from MDHHS;
      e. Maintain an accurate, secure record system for requests for Administrative Hearings (HBH and the NorthCare Customer Services Grievance Database);
      f. If the hearing request is received before the date of action Advance Notice notify the appropriate supervisor that services must be continued until a hearing decision has been rendered;
      g. Schedule a room and appropriate equipment for the hearing.
   3. The Hearings Officer will:
      a. Offer a pre-hearing conference to the consumer to see if the issues can be resolved;
      b. Prepare a Hearing Summary and documents to be used as evidence during the hearing and submit this to MDHHS and the appellant. If the Hearings Officer is not the staff responsible for presenting the case at the hearing, the Hearings Officer will assist the staff in preparing for the hearing;
      c. Present the agency's case at the hearing unless a different staff is assigned this responsibility.

C. Maintaining Medicaid covered services and supports
   1. If HBH mails the advance notice of adverse action impacting Medicaid covered services as required and the consumer or his/her authorized representative requests a MDHHS hearing before the date of action in lieu of, or in addition to, filing an appeal, HBH may not terminate or reduce services until a decision is rendered unless:
      a. It is determined at the hearing that the sole issue is one of Federal or State law;

AND

b. HBH promptly (i.e., in the advance notice) informs the consumer that services are to be terminated or reduced pending the MDHHS hearing decision.

2. If HBH's action is sustained by the Fair Hearing decision, HBH may seek reimbursement from the consumer for the cost of any services provided the consumer during this period of time, up to the individual's ability to pay as determined by the Code. The consumer must be informed in advance of their potential responsibility to pay for services received during the appeal process.

D. Reinstatement of Medicaid covered services

1. HBH must reinstate Medicaid covered services if a consumer or his/her authorized representative requests a MDHHS Administrative Fair Hearing not more than twelve (12) calendar days after the date of action.
2. The reinstated Medicaid covered services must continue until the hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
3. HBH must reinstate and continue Medicaid covered services until a hearing decision, if:
    a. Action was taken without the required Advance Notice; AND
    b. The consumer or his/her authorized representative requests a hearing within twelve (12) calendar days of the mailing of the notice of action; AND
    c. HBH determines that the action resulted from factors other than the application of Federal or State law or policy.
4. If a consumer's whereabouts are unknown, as indicated by return of mail that could not be forwarded, any discontinued Medicaid State Plan, Alternative services or Waiver services must be reinstated if his/her whereabouts become known during the time he/she is eligible for services.

XII. RECORDKEEPING AND REPORTING REQUIREMENTS

HBH must maintain a record of appeals and grievances and their disposition that is available for review by state officials. Aggregate reports following the HIPAA privacy regulations shall be available to HBH's Quality Council, Utilization Management, Corporate Compliance Committee and Customer Services /CFAP Committees through the applicable committee chairpersons. Northcare will be informed of any pending Tribunal Medicaid Hearings. A copy of the disposition will be forwarded to Northcare.

XIII. REFERENCES

42 CFR Chapter IV, Subpart E, sections 431.200 *et seq*
42 CFR Chapter IV, Subpart F, Sections 438.402 to 424
Michigan Mental Health Code, Act 258 of the Public Acts of 1974 as Amended
Michigan PA 516 of 1996
Managed Mental Health Supports and Services Contract Attachment
Michigan Department of Health & Human Services Medicaid Provider Manual for Specialty Mental Health Services
MDHHS Contract Attachment