Appeals and Grievances Process

Policy and Procedure: 3.6.17
Appeals and Grievances

Reviewed 9/2025

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Purpose

- Consumers of CEI must receive "due process" whenever benefits are denied, reduced or terminated.
- Consumers of CEI have a right to the grievance process.
- A grievance system must be in place at all organizations that serve Medicaid beneficiaries.

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Definitions of Actions

- Action: A decision that adversely impacts a consumer's claim for services due to:
  - Denial of a requested service, including the type or level of service;

    or
  - Reduction, suspension, or termination of a previously authorized service.

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Definitions Continued

- **Appeal**: a request to review an action (change or denial in services).
- **Due Process:** fair treatment throughout grievance system
- **Grievance:** consumers dissatisfaction about a service issue that is not eligible for appeal.
- **Grievance System:** Federal terminology for the overall local system of grievance and appeals, including access to the state fair hearing process.
- **Fair Hearing:** Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a Michigan Department of Health and Human Services (MDHHS) Administrative Law Judge. Also referred to as "Administrative Hearing" or "Tribunal".

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How are consumers notified about the grievance system?

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Notification about Process

- At initial face-to-face assessment:
  - Each new consumer is offered a copy of the MSHN Member Handbook
- Annual Intake
  - Each consumer is offered a new copy of the MSHN Member Handbook
- When/As information need arises
  - When services are being denied, reduced, suspended or terminated
- When requested by consumer/authorized representative
  - Can get information about process from the Customer Service Department

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What is included in notification during the initial and annual assessment?

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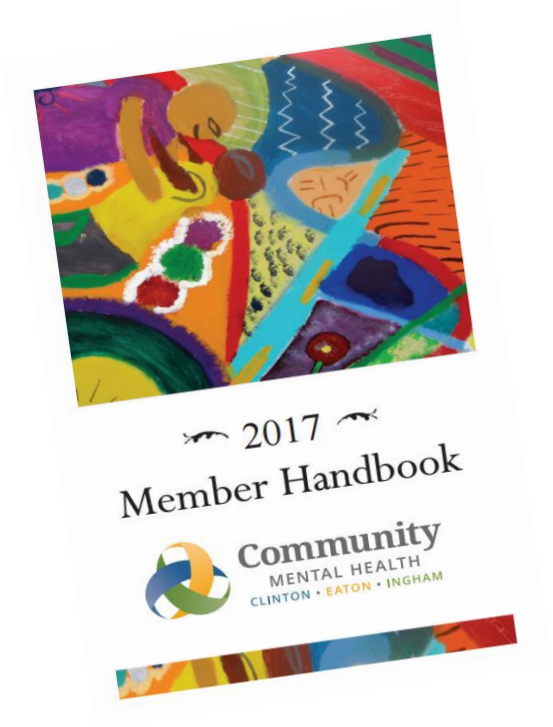
Initial and Annual Notification



- Each consumer of CEI will be provided the MSHN Member Handbook during the initial and annual assessment
- The MSHN Member Handbook provides information on the Grievance and Appeal Process

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What is included in Notification when services are denied, reduced, suspended or terminated?

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Notification documents include:

Denial of Initially Requested Services (to become a consumer at CEI)	Reduction, Suspension, Termination of Services already Receiving, or Denial of Additionally Requested Services
Cover Letter	Cover Letter
Adverse Benefit Determination Notice	Adverse Benefit Determination Notice
Request for Internal Appeal form	Request for Internal Appeal form
Community Resource List	Community Resource List
Second Opinion Request Form	

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What's the difference between Denial of Initially Requested Services and Denial of Additional Services?

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Denial Differences

Denial of Initially Requested Services:

- This is the denial for the person to receive <u>any</u> services at CEI

Denial of Additionally Requested Services:

- The consumer is already receiving services from CEI and requests for additional services

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Who is responsible to give Notification of change or denial of services?

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Programs that make the decision to deny or change services are responsible for notifying that consumer.

Ask your direct supervisor about your program's process for giving Notification.

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When should a consumer be notified of a change in services?

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When Changing Current Services

Notice must be given at least 14 calendar days prior to (formally referred as 17 day notice)

- Reducing, suspending, or terminating currently authorized services.

So, the Effective Date of the Action indicated on the Notice document (completed in SmartCare) will be at least 14 calendar days into the future of the date the Notice form is completed.

Giving prior notice allows consumers to determine if they would like to appeal PRIOR to the change in services happens.

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When denying initial services at CEI

Notify- at the time of a decision/action:

- Following an Intake Assessment

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For more information on Notification please refer to the SmartCare User guide:

Adverse Benefit Determination Notification

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Grievances and Appeals

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	Grievance	Appeal
Definition	If a consumer has an issue or problem about the services they are receiving then they may file a GRIEAVANCE.	If a consumer does not agree with the service providers decision to deny, terminate, reduce or suspend services then they may file an APPEAL.
Time Frame	Grievances can be filed at any time.	Appeals must be filed within 45 days of notice of a denial or change in service.
Example	"I don't like my case manger, we just don't connect."	"I was denied additional services when I asked for them and I want those services."

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Who can file a grievance or appeal?

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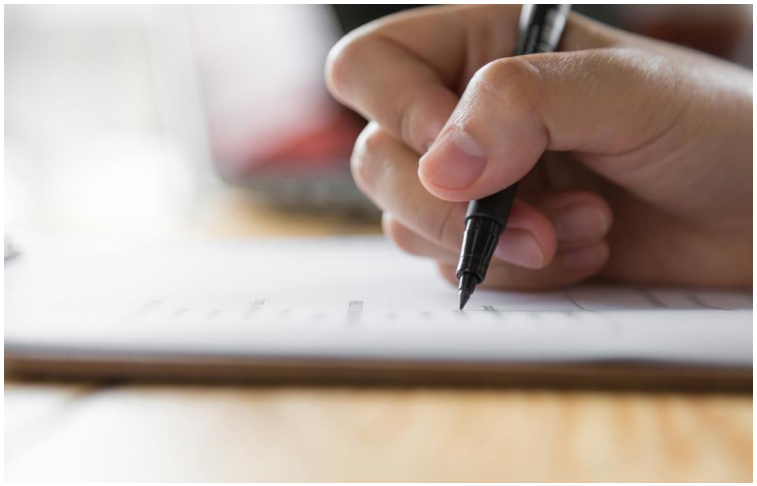
Grievances or appeals are filed by the consumer or:



- Legal Guardian
- Parent/Guardian of Minor
- Authorized Representative – an individual given written permission to act for the consumer in any grievance or appeal

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How does a consumer file a grievance or appeal?

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Consumer can file in many different ways

- Official form
- Verbally
- Email
- Fax
- Written on scrap paper

A consumer can file in any manner they wish, but the consumer must identify themselves.

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Where should a grievance or an appeal be sent?

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Grievance and appeal requests are sent to the Quality, Customer Service and Recipient Rights Department (QCSRR).

The QCSRR Department receives, documents and responds to grievances and appeals.

Forward requests to Customer Service:

Phone: 346-8244

Email: customerservice@ceicmh.org

Fax: 346-8245

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Grievance Overview

- If an issue can be quickly resolved and the consumer is satisfied then a grievance does not have to be filed.
- The grievance process is for consumers who may want a formal response. This process also helps to bring in a neutral third party to help mediate if needed.
- Remember that CEI is person and family centered and consumers have the right to the grievance process.

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Examples of a grievance

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Grievance Example 1

- Bob lives in a group home and feels that some of the workers are denying him privileges.
- He does not feel comfortable bringing this up to the workers in the home, so he calls Customer Service.
- Customer Service asks if he would like to file a grievance?
- Bob says yes, and Customer Service helps him file a grievance.
- The Quality, Customer Service, & Recipient Rights (QCSRR) Department follows up with appropriate staff members to come up with a solution.
- The QCSRR Department is responsible for sending a resolution letter to the consumer.

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Grievance Example 2

- Sally is upset that she gets to the clinic at 7:30 am for her appointment and has to wait in the hall because the clinic does not open until 8:00 am.
- Sally calls the Recipient Rights (RR) office to file a complaint.
- The RR office determines that it is not a rights issue but that she can file a grievance if she wishes.
- Sally says she does, so the RR office transfers Sally to Customer Service.
- The QCSRR Department works with Sally and the clinic to find a resolution.
- The QCSRR Department sends a resolution letter to Sally.

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How are appeals resolved?

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Appeal Procedure

Once an appeal is received by the QCSRR Department:

- The QCSRR Department sends an acknowledgment letter to the consumer that the appeal has been received, that it will be reviewed, and they will get a decision within 30 days.
- Involved staff will convene a meeting to discuss the appeal.
- The Director of the program with input from staff will come to a decision.

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Appeal Procedure continued

- The QCSRR Department will mail a disposition letter to the consumer within 30 days with the outcome.
- If the consumer agrees with the outcome, then the appeal is closed.
- If the consumer does not agree with the outcome, they may file for a Fair Hearing within 120 days.

The consumer must go through an internal appeal before they can file for a Fair Hearing.

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Service Continuation

A consumer may request that previously authorized services continue during the appeal or fair hearing process

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State Appeal Process

Administrative Fair Hearing

- Impartial state level review of a **Medicaid Beneficiary's** appeal of an action presided over by an Administrative Law Judge. Medicaid beneficiaries can request a hearing after a Local decision is reached after an Internal Appeal. The Michigan Administrative Hearing System (MAHS) is the oversight body, also known as the Tribunal.

MDHHS Alternative Dispute Resolution Process

- Impartial state level review of an appeal presided over by MDHHS staff. This process is for **consumers without Medicaid**. It can be accessed only after an internal appeal is exhausted and the consumer is not satisfied with the result.

Check out: http://www.michigan.gov/mdhhs/ for detailed information on the state appeal process

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Underlying Values

The appeal and grievance process strives to be:

- Timely
- Fair to all parties
- Administratively simple
- Objective and credible
- Accessible and understandable to consumers
- Cost and resource efficient
- Subject to quality review

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Underlying Values

The Appeal and Grievance Process should:

- Not interfere with communication between consumers and their service providers.
- Assure that consumers who file a grievance should be free from discrimination or retaliation.

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Important Contact

Customer Service Department

Phone: 346-8244

Email: customerservice@ceicmh.org

Fax: 346-8245

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References

- CMH CEI Policy 3.6.17 Appeals and Grievances
- CMH CEI Procedures Appeals and Grievances

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THANK YOU

for completing
"Grievance and Appeal Process"
You must complete the test to
receive credit for this course.

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