BERRIEN MENTAL HEALTH AUTHORITY
PROCEDURE

SUBJECT: CCBHC Appeal and Grievance Resolution Process for Medicaid and non-Medicaid Beneficiaries	SECTION: CCBHC 01-80-01 Page 1 of 12
APPLICATIONS: Customer Service, Recipient Rights, Clinical Staff EFFECTIVE DATE: 10/01/2025 APPROVED BY: Chief Executive Officer REVISED:	REQUIRED BY: Michigan Mental Health Code Chapters 7 and 7A, Federal Law, 42 CFR, CARF, MDHHS Master Contract

POLICY: It is the policy of Berrien Mental Health Authority (BMHA) that all persons served have the right to a fair and efficient process for resolving disputes and complaints related to the denial, reduction, suspension or termination of their services and supports. BMHA will handle and process complaints in ways consistent with the policies set forth by the Michigan Department of Health and Human Services (MDHHS) for Certified Community Behavioral Health Clinic (CCBHC) services. Throughout this policy, all references to "CCBHC" shall be understood to mean BMHA.

PURPOSE: To ensure that BMHA practices align with MDHHS standards for CCBHC services for individuals with both Medicaid and non-Medicaid coverage.

DEFINITIONS:

Certified Community Behavioral Health Clinic (CCBHC): A specially designated clinic that provides a comprehensive range of mental and substance use disorder services. CCBHCs are nonprofit organizations or units of a local government behavioral health authority. They must provide nine (9) types of services, either directly or by contracting with partner organizations, with an emphasis on providing 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care. CCBHCs are available to anyone who walks through the door, regardless of age, diagnosis, insurance status, or residency. The MDHHS CCBHC Demonstration is authorized under Section 223 of the federal Protecting Access to Medicare Act (PAMA) of 2014, the federal CARES Act of 2020, and the Bipartisan Safer Communities Act of 2022. Throughout this policy, all references to "CCBHC" shall be understood to mean BMHA.

Community Mental Health Services Program (CMHSP): A CMHSP is a program that contracts with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of a person's ability to pay.

Designated Collaborating Organization (DCO): An entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as a CCBHC. *BMHA provides all CCBHC services, with no Designated Collaborating Organization (DCO) in place.*

Expedited Appeal: The expeditious review of an Negative Action Determination, requested by an person served or the person served's provider, when the appropriate party determines that taking the time for a

standard resolution could seriously jeopardize the person served's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the person served requests the expedited review, the CCBHC and/or Michigan Office of Hearing and Rules (MOAHR) determines if the request is warranted. Should the CCBHC deny the request, the person served or the person served's provider may appeal to MDHHS via the MDHHS Dispute Resolution Process for non-Medicaid enrollees, or the MOAHR State Administrative Hearing Process for Medicaid beneficiaries.

Grievance: The person served' s expression of dissatisfaction with the CCBHC about any matter other than a negative action determination notice. This may include, but is not limited to, any aspect of the operations, activities, or behavior of the CCBHC regardless of whether remedial action is requested. Specific examples include the quality of care or services provided, problems getting an appointment or having to wait a long time for an appointment, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the person served's right to dispute an extension of time proposed by the CCBHC to make a service authorization decision. BMHA will provide reasonable assistance including an advocate to assist the person served to complete the grievance forms.

Who can file a Grievance: A grievance may be filed by the person served, their guardian, their authorized representative, or parent of a minor child. A person served can file a grievance either orally or in writing. A grievance can be filed at any time.

Grievance Process: Impartial local level CCBHC review of the person served's/beneficiary's expression of dissatisfaction with the CCBHC about any matter other than a negative action determination notice.

Local Appeal/Internal Review: A request a person served can make to ask that a decision that the CCBHC made is impartially looked at again by the CCBHC related to a Negative Action Determination. This is also called a "local dispute resolution process" or "Appeal."

MDHHS Alternative Dispute Resolution Process: A formal process used when persons served without Medicaid who disagree with the outcome of a local appeal/internal review decision from a CCBHC file a request with MDHHS. This process allows MDHHS to attempt to resolve the issue with the person served and the CCBHC.

Negative Action Determination: A written decision that adversely impacts the CCBHC person served's/beneficiary's claim for services due to*:*

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of an authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the CCBHC.

- Failure of the CCBHC to resolve standard appeals and provide notice within **30 calendar days (Medicaid) or 45 calendar days (Non-Medicaid)** from the date the standard appeal request is received by the CCBHC.
- Failure of the CCBHC to resolve expedited appeals and provide notice within **72 hours** from the date the expedited appeal request is received by the CCBHC.

Mediation: Medicaid and non-Medicaid CCBHC service recipients have a right to mediation. A recipient or a recipient's representative can request mediation at any time when there is a dispute related to service planning or the services and/or supports provided by the CCBHC. The Customer Services representative will assist with information.

Notice of Resolution: Written statement or letter from the CCBHC of the resolution of an Appeal or Grievance, which must be provided to the person served.

Office of Recipient Rights: Each CMHSP is required to establish this office in accordance with all the provisions of Section 4, 4a, 7, and 7a of the Michigan Mental Health Code and corresponding administrative rules, as well as Section 6321 of P.A. 365 of 1978 and related administrative rules. The CMHSP must ensure that education and training in recipient rights are provided to all appropriate staff, committees, and/or advisory groups. The Office of Recipient Rights must ensure that they are protected from pressures that could interfere with the impartial, even-handed, and thorough performance of its duties. The Office is required to ensure that recipients are protected from rights violations, that the telephone number and address of the Office is conspicuously posted in all service sites, maintain a record system of logging all complaints and a mechanism to securely store all documents and evidence, et.al.

Person served: A person who is receiving services at a CCBHC.

Provider: An individual or entity engaged in the delivery, ordering, or referring of services.

Recipient 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 Mental Health Code protected right cited in Chapter 7, which is resolved through the processes in Chapter 7a.

State Administrative Hearing: Impartial state-level review of the Medicaid beneficiary's appeal of a Negative Action Determination. The Hearing is presided over by an MDHHS Administrative Law Judge (ALJ). Also referred to as a "State Appeal Hearing" or "Medicaid Fair Hearing." Medicaid beneficiaries are not required to exhaust a local appeal/internal review process before filing a request for a State Administrative Hearing.

GENERAL REQUIREMENTS

In addition to the rights, benefits, and privileges guaranteed by other provisions of law, the State of Michigan Constitution of 1963, the Constitution of the United States, a person served by a CCBHC must be guaranteed the rights by the Michigan Mental Health Code Chapter 7 and 7A[1]. All CCBHC recipients

must have access to the same array of services and supports, regardless of their level of need, residence, insurance, or eligibility for Medicaid.

All CCBHC recipients will receive annual written notice of their rights guaranteed by the Mental Health Code along with a written explanation of the grievance and appeals processes. All recipients will receive notices in a format and manner that is easily understood, is readily accessible by persons served, and meets the needs of those with limited English proficiency and/or limited reading proficiency.

In some situations, a person served may be receiving CCBHC eligible services at a CCBHC and non-CCBHC services from a different provider. Grievances and appeals must follow the person served's service delivery, with grievance and appeal responsibilities remaining with the provider where the grievance/appeal occurred. The CCBHC must assist the person served to identify which process must be used and ensure the person served has access to the appropriate grievance/appeal process.

BMHA will follow all policies and practices established by MDHHS. Responsibilities may change as the demonstration evolves, and CCBHCs are required to comply with all MDHHS policies and practices.

PROCEDURES:

RECORDKEEPING REQUIREMENTS

All CCBHCs must have an established process to receive, track, and maintain records of each grievance and/or appeal received both orally and in writing as required by federal and state regulations.

The records must be accurately maintained and reviewed by the CCBHC on a regular basis as part of the CCBHC's quality strategy and quality improvement program. The records must be available to MDHHS upon request. At a minimum, the record must contain:

1. A general description of the reason for the grievance and/or appeal.
2. The date that the CCBHC received the grievance and/or appeal.
3. The date that written acknowledgement was provided to the person served.
4. The date of each review and each decision made.
5. The final disposition of the grievance/appeal.
6. The date of resolution.
7. The date the CCBHC notified the person served of the final disposition.
8. The name of the person served/beneficiary for whom the grievance and/or appeal was filed.

CCBHC APPEAL AND GRIEVANCE RESOLUTION PROCESSES

I. Grievance Process for Medicaid and Non-Medicaid Persons Served

<u>Generally</u>

1. The grievance must be filed with the CCBHC department that is responsible for facilitating the resolution of grievances.
2. A grievance may be filed by the person served, their guardian, their authorized representative, or

parent of a minor child. A person served can file a grievance either orally or in writing. A grievance can be filed at any time.

Responsibility when a person served files a grievance:

1. Acknowledge receipt of the grievance in writing within **five (5) business days** and maintain a record of the grievance.
2. The CCBHC must ensure that the staff who make the decision on the grievance are:
   a Staff who were neither involved in any previous level review or decision-making, nor subordinate to any such individual.
   b Staff who have the appropriate clinical expertise, as determined by the State, in treating the person served's condition or disease for a grievance that involves clinical issues.
   c Staff who will consider all comments, documents, records, and other information submitted by the person served and/or the person served's representative without regard to whether such information was submitted or considered previously.
3. Once a decision has been made, a Notice of Grievance Resolution must be sent to the person served (in addition to the authorized representative if applicable) and include the results of the grievance process and the date the grievance process was concluded.
4. Provide the person served with written notice of a grievance resolution **not to exceed 90 calendar** days from the date the oral or written grievance was received.
5. Resolving grievances is a top priority, and due diligence will be used to ensure they are resolved promptly.
6. The timeframe may be extended by up to **14 calendar days** if the person served requests the extension or if the CCBHC can justify the need for additional information and document how the delay is in the best interest of the person served. If the CCBHC grants an extension, it must notify the person served in writing within **two (2) calendar days**, explaining the reason for the delay and informing them of their right to file an expedited grievance if they disagree with the decision to extend the timeframe.
7. The Notice of Grievance Resolution must include notification of the right to request access to the MDHHS Alternative Dispute Resolution Process. Access to the MDHHS Alternative Dispute Resolution Process does not require agreement by both parties to be initiated. The person served (or their authorized representative if applicable) can solely initiate the process by requesting access to the MDHHS Alternative Dispute Resolution Process within ten (10) calendar days from the date the Notice of Grievance Resolution is received.
8. At any time during the internal grievance process, or the MDHHS Alternative Dispute Resolution process, a person served is entitled to withdraw his/her grievance at any time. The withdrawal will be accepted and documented in the record.
9. For withdrawals by telephone, the person served's statement and telephonic signature will be documented.
10. Written confirmation will be sent to the person served for all withdrawals.

The person served can send a request for an MDHHS Alternative Dispute Resolution Process via email to:

MDHHS-CCBHC@michigan.gov

or via U.S. Mail to:

Michigan Department of Health and Human Services

RE: Request for MDHHS Alternative Dispute Resolution
Behavioral Health Transformation Division Director
Capitol Commons Center
400 South Pine Street – 7th Floor
Lansing, MI 48913

II. Appeals Process

A. Non-Medicaid Persons Served – Local Appeal/Internal Review and Dispute Resolution

1. The person served has **30 calendar days** from the date of the Negative Action Determination Notice (for denials, reduction, suspension or termination of services) to initiate a local appeal/internal review.
2. Appeal will be resolved within **45 calendar days** from the request for local appeal/internal review and within **72 hours** for a fast appeal involving reduction, suspension or termination of services.
3. Ensure the staff person making the decision on appeals:
    a. Have the authority to provide resolution or require corrective action.
    b. Was not the same staff person(s) or his/her subordinate who made the initial decision that is subject to the dispute.
4. Written Notice of Resolution is provided to the person served including subsequent avenues available if the person served is not satisfied with the result, including the right to access the MDHHS Alternative Dispute Resolution process after exhausting this local dispute resolution procedure.
5. Reports of local appeals/internal reviews will be reviewed by the CCBHC Quality Improvement Program to identify opportunities for improvement.
6. Records of local appeals/internal reviews must be made available to MDHHS for review upon request.

Notice of Negative Action Determination

Whenever currently authorized services and/or supports are to be suspended, terminated, or reduced the person served must be informed in writing. The written notification of the change is completed at least **thirty (30) calendar days** prior to the effective date of the action. The notice is called a Negative Action Determination Notice.

BMHA utilizes PCE to document the Negative Action Determination and the Appeal, which contain all required information as listed below:

1. A statement of what action the CCBHC intends to take.
2. The reasons for the intended action, including the right of the person served to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the negative action determination.
3. The specific rules and regulations that support the action the CCBHC is taking.
4. The right of the person served to request a local appeal/internal review.

5. The amount of time a person served has from the date of the Notice to request a local appeal/internal review.
6. An explanation of the local appeal/internal review process (also called Local Dispute Resolution Process).
7. Notification of the person served's right to have benefits continue pending resolution of the Local Dispute Resolution Process if they appeal before the date of the proposed Negative Action, as well as the MDHHS Alternative Dispute Resolution Process, with instructions on how to request that benefits continue and a description of the circumstances under which the person served may be required to pay the costs of the continued services.
8. Description of steps or procedures that the person served is required to follow to exercise any of these rights.
9. An explanation that a person served may represent himself/herself or use legal counsel, a relative, a friend, or other spokesperson.

Written notice about service authorization decisions must be provided (including service denials) within **14 calendar days** from the date of the standard request for service. If a denial, the decision must be made in a written Negative Action Determination Notice, including the requirements described in items 1-9 above.

Additionally, when a CCBHC does not start providing services within **14 calendar days of the start date agreed upon** during the person-centered planning (PCP) meeting, a written notice of Negative Action Determination must be provided as described in items 1-9 above.

Notice of Resolution

In the event that a person served utilizes the Local Dispute Resolution Process, the CCBHC must communicate in writing the outcome of that process (**within 45 days or 72 hours if a fast appeal**) to the person served (in addition to the authorized representative if applicable) with a Notice of Resolution. The communication must include notification to the person served of the right to request access to the MDHHS Alternative Dispute Resolution Process. Access to the MDHHS Alternative Dispute Resolution Process does not require agreement by both parties to be initiated. The person served (or their authorized representative if applicable) can solely initiate the process. The person served must request access to the MDHHS Alternative Dispute Resolution Process within **ten (10) calendar days** from the date the Notice of Resolution is received by the person served.

The person served can send a request for an MDHHS Alternative Dispute Resolution Process via email to:

MDHHS-CCBHC@michigan.gov

or via U.S. Mail to:

Michigan Department of Health and Human Services
RE: Request for MDHHS Alternative Dispute Resolution
Behavioral Health Transformation Division Director
Capitol Commons Center

400 South Pine Street – 7th Floor
Lansing MI 48913

B. <u>Medicaid</u> Persons Served – CCBHC Appeal and State Administrative Hearing

Medicaid beneficiaries are entitled to Due Process whenever their Medicaid benefits/services are denied, reduced, suspended, or terminated.

Due Process requires that persons served receive:

1. Advance written notice of the negative action.
2. A hearing before an impartial decision maker.
3. Continued benefits pending a final decision.
4. A timely decision measured from the date the appeal is first received.

Medicaid beneficiaries have the right to request a hearing to contest any negative action involving the denial, reduction, suspension, or termination of Medicaid benefits/services.

The system must be accessible to persons who are limited English proficient and persons who have disabilities.

The Appeal system will provide the following:
BMHA utilizes PCE to document the Negative Action Determination and the Appeal, which contain all required information as listed below.

1. A CCBHC Appeals/Internal Review process for beneficiaries to dispute Negative Action Determinations made by the CCBHC should the beneficiary decide to;
2. Access to the State's Administrative Hearing process without requiring the exhaustion of the CCBHC Appeal/Internal Review.
3. The right to concurrently file a CCBHC Appeal or State Administrative Hearing request to dispute Negative Action and a Grievance following the process above regarding other service complaints should the beneficiary choose to do so.
4. Information that states if the CCBHC fails to adhere to notice and timing requirements as required, that the beneficiary can initiate a State Administrative Hearing to contest the negative action regarding Medicaid benefits and services.
5. The right of the beneficiary to have the affected Medicaid services continued while the CCBHC Appeal process and State Administrative Hearing is pending when timely filed.
6. An explanation that a beneficiary may represent himself/herself or use legal counsel, a relative, a friend, or other spokesperson.

Medicaid beneficiaries served by CCBHCs must also be afforded an expedited review process through a CCBHC fast appeal process when it is determined that the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Beneficiaries are notified of their right to a fast (expedited) Administrative Hearing pursuant to 42 CFR 431.224.

Notice of Negative Action Determination

Whenever currently authorized services and/or supports are to be suspended, terminated, or reduced the person served must receive written notification of the change called a Negative Action Determination Notice **at least 30 calendar days prior to the effective date of the action**.

BMHA utilizes PCE to document the Negative Action Determination and the Appeal, which contain all required information as listed below:

1. A statement of what action the CCBHC intends to take.
2. The reasons for the intended action, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the negative action determination.
3. The specific rules and regulations that support the action the CCBHC is taking, including CCBHC policies.
4. The right of the beneficiary to file a CCBHC Appeal/Internal Review or file for a State Administrative Hearing and the amount of time a beneficiary has from the date of the negative action determination notice to request either of these processes (**60 calendar days for a CCBHC Appeal** and **90 calendar days for a State Administrative Hearing**).
5. An explanation of the CCBHC Appeal/Internal Review process, and the State Administrative Hearing process.
6. Notification of the beneficiary's right to have benefits continue pending resolution of the CCBHC Appeal and the State Administrative Hearing if timely filed (before the date of the proposed Negative Action), with instructions on how to request that benefits continue and a description of the circumstances (consistent with State policy) under which the beneficiary may be required to pay the costs of the continued services[8].
7. Description of steps or procedures that the beneficiary is required to follow to exercise any of these rights.
8. An explanation that a beneficiary may represent himself/herself or use legal counsel, a relative, a friend, or other spokesperson.
9. The right of the beneficiary to concurrently file a CCBHC Appeal/Internal Review, a State Administrative Hearing request, and a Grievance following the process above (regarding other complaints) should the beneficiary decide to. The beneficiary does not have to exhaust the CCBHC Appeal/Internal Review process to file a request for a State Administrative Hearing.

A CCBHC must provide written notice about service authorization decisions (including service denials) within **14 calendar days** from the date of the standard request for service.

If a denial, the decision must be provided in a written Negative Action Determination Notice, including the requirements described in items 1-9 above.

Additionally, when a CCBHC does not start providing services within **14 calendar days** of the start date agreed upon during the person-centered planning (PCP) meeting, a written notice of Negative Action Determination must be provided as described in items 1-9 above.

Further, beneficiaries are entitled to file a request for a State Administrative Hearing when:

1. The CCBHC does not resolve standard appeals and provide notice within 30 calendar days from the date the appeal request is received by the CCBHC.
2. The CCBHC does not resolve expedited (fast) appeals and provide notice within 72 hours from the date the expedited (fast) appeal request is received by the CCBHC.

NOTE: Denials or Actions taken (termination, suspension, or reduction) as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action, unless the treatment plan was signed in dispute.

CCBHC Appeal/Internal Review

The beneficiary has **60 calendar days** from the date of the Notice of Negative Action Determination to request a CCBHC Appeal/Internal Review through the CCBHC. The CCBHC Appeal/Internal Review request can be made orally or in writing. The CCBHC must provide reasonable assistance with completing forms and other steps, this includes an advocate or the Customer Service Representative. The CCBHC must acknowledge receipt of the CCBHC Appeal/Internal Review request within **five (5) business days in writing** and maintain records as required.

The CCBHC/DCO must ensure that staff who make the decision on the CCBHC Appeal/Internal Review are:

1. Staff who were neither involved in any previous level review or decision-making, nor subordinate to any such individual.
2. Staff who have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease for an appeal that involves clinical issues.
3. Staff who will consider all comments, documents, records, and other information submitted by the beneficiary and/or the beneficiary's representative without regard to whether such information was submitted or considered previously.

Notice of Resolution

The CCBHC must provide the beneficiary with written Notice of Resolution **not to exceed 30 calendar days** (**72 hours for a fast appeal**) from the date the CCBHC/DCO receives the Appeal/Internal Review request. The Notice may **not stop continuing benefits until at least 10 calendar days after the Notice of Resolution is mailed** to the beneficiary if the decision is not in the beneficiary's favor. Services must continue pending the CCBHC Appeal/Internal Review process. The CCBHC Appeal/Internal Review process stays (pauses) the statute of limitations on filing a State Administrative Hearing request.

The CCBHC may extend the timeframe for a decision **up to 14 calendar days** if the beneficiary requests the extension or if the CCBHC justifies a need for additional information and can document how the delay is in the interest of the beneficiary. When the CCBHC extends the deadline, it **must inform the beneficiary in writing within two (2) calendar days** of the reasons for the delay and the right of the beneficiary to file an expedited review if the beneficiary disagrees with the CCBHC decision to grant an extension.

The Notice of Resolution must include the results of the resolution process, the date it was completed, and, if the CCBHC Appeal/Internal Review decision is adverse to the beneficiary, must include the beneficiary's

right to file a request for State Administrative Hearing, the beneficiary's right to continue to receive benefits while the State Administrative Hearing is pending if timely filed (**10 calendar days**), and the timeframe for filing a request for a State Administrative Hearing (**90 calendar days**).

Information about the State Administrative Hearing and benefit continuation must be included in the notice, including that the beneficiary may be held liable for the cost of those benefits if the State Administrative Hearing decision upholds the CCBHC negative action determination.

The CCBHC must not limit or interfere with the beneficiary's freedom to make a request for a State Administrative Hearing.

State Administrative Hearing

The beneficiary must file a request for a State Administrative Hearing within 90 calendar days (3 months) from the date of the Notice of Negative Action or Notice of Resolution. Services must continue pending the State Administrative Hearing process where applicable.

The Michigan Office of Administrative Hearings and Rules (MOAHR) Benefit Services Division (BSD) holds impartial administrative hearings for MDHHS related to Medicaid beneficiaries who are contesting action taken by Medicaid providers. To request a State Administrative Hearing, a beneficiary must complete and submit to MOAHR a Beneficiary Form*: **Request for Hearing for Medicaid Enrollees, PACE Enrollees, or Waiver Applicants (DCH-0092),"*** which is available on the MOAHR website here: Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services

Once the form has been completed, Page 1 can be faxed to: Fax**: 517-763-0146**

Or sent via U.S. Mail to:
Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909

Or sent via email to:
LARA-MOAHR-DCH@michigan.gov.

A beneficiary can also call for more assistance and information:
800-648-3397 (TTY users can call 711)

A beneficiary may choose to have another person represent the beneficiary at a hearing. That person must be at least 18 years of age. The beneficiary must give written permission for another person to represent the beneficiary. The beneficiary's guardian or conservator may represent the beneficiary with a copy of the court order naming the guardian or conservator being included with the DCH-0092 form.

Withdrawal

At any time during the CCBHC Appeal/Internal Review process or the State Administrative Hearing process, a beneficiary is entitled to withdraw his/her request. The CCBHC must accept the withdrawal; however, MOAHR determines if the withdrawal is valid for administrative hearing purposes. For withdrawals by telephone, the CCBHC must record the beneficiary's statement and telephonic signature. For all types of withdrawal notifications from beneficiaries, the CCBHC must record the withdrawal and send the beneficiary written confirmation of the withdrawal.

REVIEWER: Customer Services, CCBHC Lead
REVIEWED: