SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

POLICY AND PROCEDURE MANUAL

Section: Recipient Rights	Effective Date: 11/9/98
Policy Number: 24	Last Revision Date: 07/26/16
Subject: **Grievance and Appeal Process**	Page: 1 of 18

Policy

It is the policy of Shiawassee County Community Mental Health Authority (SCCMHA) that the Customer Service Representative will process all grievance and appeals, not related to Recipient Rights, who will implement the Michigan Department of Health and Human Services (MDHHS) technical requirements for appeals and grievances.

It is the policy of SCCMHA to establish and implement a grievance and appeals process for resolving applicant/consumer complaints regarding services and supports at a local level. At this time SCCMHA adheres to the technical requirements issued by MSHN related to grievance appeal standards and systems.

It is the policy of SCCMHA that grievance and appeals processes will enhance the goal of improving the quality of care.

It is the policy of SCCMHA that if at any time during the grievance and appeals process an applicant/consumer needs translator services those services will be provided in accordance with SCCMHA's "Service to Consumers with Limited English Proficiency" policy. If a consumer requires large print materials, all notices and written communication provided to that person will be typed in a font large enough for the individual to read.

Purpose

To ensure that all consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by SCCMHA.

To ensure compliance with the Michigan Mental Health Code, the MDHHS/CMHSP Managed Care and Supports and Services Contract, and federal law, 42 CFR 434.32.

Application

This policy applies to all consumers of services managed or provided by SCCMHA, all staff of the agency, and all contract providers.

Definitions

Action: A determination impacting a customer's services such as denial, reduction, suspension, or termination of service.

Appeal: A customer's request for a review of an adverse action (Note: For both Medicaid and Non-Medicaid customers).

MDHHS Medicaid Fair Hearing: An impartial review by a MDHHS Administrative Law Judge of a decision regarding public mental health and/or substance abuse services specific to a customer. A customer completes the necessary process to access this service with CMHSP assistance as needed.

Grievance: A customer's dissatisfaction about any matter relative to a service, other than an action as defined above, which does not involve a rights complaint as defined below. Possible subjects of grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the customer. (Note: For Medicaid and Non-Medicaid customers)

Informal Dispute Resolution: A process by which the customer may resolve grievances or appeals directly with the treating staff, supervisor, or administrator prior to accessing the formal Local Appeal and Grievance Process and/or MDHHS Medicaid Fair Hearing/Dispute Resolution Processes.

Local Grievance and Appeal Request (LGAR): Form to initiate a grievance or appeal through the Informal Dispute Resolution.

Legal Representative: An individual who has legal authority to act on a customer's behalf, i.e. guardian and/or durable power of attorney.

MDHHS Alternative Dispute Resolution: MDHHS dispute resolution process established to provide an Administrative forum for grievances and disputes by consumers of public mental health and public substance abuse services who are not covered by the federal standards related to a State Fair Hearing.

MDHHS State Fair Hearing: An impartial review by a MDHHS Administrative Law Judge of a decision regarding public mental health and/or substance use disorder services specific to a customer. A customer completes the necessary process to access this service with PIHP, CMHSP, or CA assistance as needed.

Person-Centered Plan (specifically for mental health services): A plan for treatment that includes clearly stated goals, measurable objectives, and methodology that specifies the amount, scope, duration, and intensity of services to be provided. The plan is derived from an assessment of the individual's condition, the customer's wishes and desires, and considers health and safety factors.

Mid-State Health Network (PIHP): The entire regional provider network for both public mental health and public substance abuse services.

Recipient Rights Complaint: A written or verbal statement made by a recipient, or anyone acting on behalf of a recipient, alleging a violation of a Michigan Mental Health Code (MMHC) protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A. The recipient rights for persons with substance use disorders is protected by the MDHHS substance abuse program licensing rules R 325.14301-325.14306.

Second Opinion Processes: Customers and/or legal representatives may request a second opinion of the CMHSP Chief Executive Officer if they would like reconsideration of a denial of psychiatric hospitalization and/or denial of mental health services.

Unreasonable Delay: Postpone of service beginning 14 or more calendar days beyond the start date agreed upon during the Person Centered Planning and as authorized.

Standards

1. Recipients of, or applicants for, SCCMHA services may pursue their complaint within multiple options, including:

    - Office of Recipient Rights
    - CMHSP Second Opinion Process
    - Informal Conflict Resolution
    - MSHN Appeal Process
    - MDHHS State Fair Hearing (if Medicaid or ABW recipient) (in relation to adverse actions)
    - MDHHS Alternative Dispute Resolution (if not a Medicaid recipient and local processes have been exhausted) (in relation to adverse actions)
    - MSHN Grievance Processes (for both Medicaid and Non-Medicaid consumers) (for all other issues that are not in relation to adverse actions or recipient rights)

2. The grievance and appeals processes of the SCCMHA will be:

    - Timely

- Fair to all parties
- Administrative simple
- Objective and credible
- Accessible and understandable to recipients and providers
- Cost and resource efficient
- Subject to quality improvement review

3. The design of the grievance and appeals processes and their application will be such as to ensure non-interference between recipients and their service provider(s).

4. Service providers who participate in a grievance and appeal process on behalf of consumers will be free from discrimination or retaliation.

5. Consumers who file a grievance will be free from discrimination or retaliation.

6. All recipients of or applicants for public mental health services will receive a written notice of their rights and an explanation of the grievance and appeal processes.

7. The person reviewing the grievance/appeal will not be the same person involved in making the initial decision that is the subject of the grievance/appeal. If the grievance/appeal involves clinical issues or issues of medical necessity, the reviewer will be a professional who has the appropriate clinical expertise in treating the recipient's condition.

8. Although it is preferred that grievances/appeals be resolved at the level closest to service delivery, all grievance/appeals processes for which they are eligible will be available to applicants/recipients simultaneously or sequentially. The exception is that the Informal Dispute Resolution must be utilized by non-Medicaid recipients before accessing the DCH Alternative Dispute Resolution Process.

9. Applicants/recipients will be provided with written notification of dispute resolution decisions and subsequent avenues available if they are not satisfied with the result.

10. All SCCMHA staff are responsible for assisting applicants/recipients or their legal representatives to access all grievance and appeal processes for which they are eligible. SCCMHA will maintain a log of second opinion requests, Family Support Subsidy appeals, Informal Dispute Resolution requests (appeals and grievances) and DCH Alternative Dispute Resolution requests. The Medicaid Fair Hearing Officer will maintain a log of all Medicaid Fair Hearing requests.

11. Quarterly reports of grievances/appeals will be provided to the Performance Improvement program and to MSHN.

12. A recipient may file a recipient rights complaint pursuant to Chapter 7 and 7A of the Michigan Mental Health Code without first exhausting the grievance or alternative dispute resolution processes. An individual receiving mental health services and supports may pursue his/her complaint within multiple options simultaneously.

13. Informal Dispute and Grievance Resolution Process

    a. The purpose of the Informal Dispute Resolution is to provide a mechanism for addressing decisions by SCCMHA and/or its provider networks which have an impact on the consumer's access to or satisfaction with services and supports.

    b. The local Informal Dispute Resolution may not supplant or replace a Medicaid beneficiary's right to file a fair hearing request with the Michigan Department Health and Human Services which may occur simultaneously. It may not supplant or replace any recipient's right to file a recipient rights complaint as protected by the Michigan Mental Health Code.

    c. The Informal Dispute Resolution will be facilitated through the region's Customer Service department.

    d. A recipient will be informed about the Informal Dispute Resolution when services are initiated, at any time during the course of service when dissatisfaction with services is expressed, or when a change in service occurs.

        i. The recipient will be offered a "Local Grievance or Appeal Request" form (LGAR) by any staff person or provider when the recipient indicates his/her intent to file a complaint. Assistance in completing the complaint will be offered and provided at the recipient's request.

        ii. The recipient may directly contact the region's Customer Service representative to file a complaint.

    e. The LGAR form will be received by the region's Customer Service or local representative within 24 working hours of its being completed by the recipient. A log of all Informal Dispute Resolution appeals and grievances received locally will be forwarded to the region's Customer Service department.

    f. If access to psychiatric inpatient services is denied the individual or if a minor, his/her parent or guardian will be informed of his/her right to a second opinion and his/her rights to file an appeal. When an Individual denied hospitalization requests a second opinion the procedures established by the Michigan Mental

Health Code Sections 409(4), 498e (4) and 498h (5) for reaching a determination will be followed.

In the event that a physician, licensed psychologist, registered professional nurse, master's level social worker, or master's level psychologist external to SCCMHA attests orally or in writing that the individual (applicant or currant recipient) meets the definition of an emergency situation as defined in Section 100a(23)(a) or (c) of the Mental Health Code, SCCMHA will assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the MDHHS Service Selection Guidelines. If psychiatric inpatient services are denied the individual, his/her guardian, or his/her parent in the case of a minor child will be informed of his/her right to a second opinion as defined by the Michigan Mental Health Code and his/her right to further contest an unfavorable second opinion with the a decision to be reached within three (3) business days.

If SCCMHA does not recommend hospitalization and an alternative service requested by the individual, his/her guardian or his/her parent are denied, SCCMHA will inform the individual, his/her guardian, or in the case of minor his/her parent of his/her ability to access the Informal Dispute Resolution process. The decision for these persons must be reached within 3 business days.

The region's Customer Service or local representative will communicate the decision and inform the individual, his/her guardian, or his/her parents of a minor child of his/her right to access the MDHHS Alternative Dispute Resolution Process.

g. When an initial applicant for SCCMHA services is denied such services, SCCMHA will inform the individual, his/her guardian, or in the case of a minor his/her parents of his/her right to a second opinion. If the applicant or his/her guardian requests a second opinion, the procedures established by the Michigan Mental Health Code, Section 705 will be followed.

h. Timeframes for Resolving Medicaid Appeals and Grievances:

i. An expedited resolution process will be used for any appeal concerning denial, reduction, suspension, or termination of services and/or supports.

1. If an emergency situation exists that would seriously jeopardize the recipient's life, health or safety as defined by the Michigan Mental Health Code and results in the filing of an appeal the

appeals will be reviewed and a written determination completed within three (3) business days following the receipt of the appeal.

2. Situations involving initial denial of access for service resulting in the filing of an appeal will be resolved in three (3) business days.

3. All appeals other than emergency situations concerning denial, reduction, suspension, or termination of services and/or supports will be resolved in forty-five (45) business days.

ii. For any Medicaid grievance other than those concerning denial, resolution, suspension, or termination of services and/or supports resolution will be reached within sixty (60) calendar days.

i. The region's Customer Services representative will provide the appellant and the grievant with written notification of the appeal or grievance decision and subsequent avenues to the individual if he/she is not satisfied with the decision. These avenues include:

i. The right of a Medicaid beneficiary to request a fair hearing.

ii. The right of individuals without Medicaid coverage to have access to the Michigan Department of Health and Human Services Alternative Dispute Resolution process after exhausting local procedures.

iii. The right of all recipients or their guardians, parent(s) of a minor child to file a complaint with the Recipient Rights Office alleging a violation of the recipient's right to treatment suited to his/her condition.

j. Medicaid Beneficiaries:

Advance notice must be given at least ten (10) business days before the intended action takes effect. Within forty-five (45) days of receipt of the advance notice of adverse action the applicant or recipient or his/her legal representative may file a LGAR through the Informal Dispute Resolution. The region's Customer Service and local representative will:

i. Log receipt of the appeal for reporting to SCCMHA's Performance Improvement program.

ii. Advise the individual, guardian, or in the case of a minor, the parent that he/she may file a request for MDHHS fair hearing in lieu of or in addition to the appeal. Information will 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.

iii. Submit the appeal to the CEO or his/her designee (includes an administrator with the authority to require corrective action), all of whom were not involved in the initial determination to deny, suspend, terminate, or reduce the service.

iv. Facilitate resolution of the appeal within forty-five (45) days of receipt.

v. Assure an expedited review of an appeal involving an emergency situation where the standard forty-five (45) day time frame would seriously jeopardize the health or life of the individual. Such a review will be completed within three (3) working days.

Within the expedited three (3) day or the standard forty-five (45) day time frame the region's Customer Service representative will provide the individual, guardian, or parent of a minor child or his/her legal representative written notification of the decision in regard to the appeal. Notice will also include:

i. An explanation of the individual, guardian, or parent of a minor child or his/her legal representative's right to request a MDHHS fair hearing and an offer of assistance in filing the request

ii. An explanation of and an offer of assistance in the processes for withdrawing any request for MDHHS fair hearing should the individual, guardian, or parent of a minor child be satisfied with the resolution of the appeal if a fair hearing was filed simultaneously.

k. The Performance Improvement program of SCCMHA will receive quarterly reports of grievances and appeals filed and their resolution. Data derived from these reports will be incorporated into the performance improvement process of the agency.

l. Appeal records will be made available to the Michigan Department of Health and Human Services for review upon request.

14. Recipient Rights requirements regarding the denial of service

a. Denial of hospitalization

i. If an individual is denied authorization for hospitalization as a result of preadmission screening performed by SCCMHA, the individual, his/her guardian, or his/her parent in the case of a minor child may request a second opinion from the CEO. The second opinion must be completed by a Licensed Psychologist or Psychiatrist. The denial of authorization will be communicated in writing.

The request for the second opinion will be processed in compliance with Sections 409(4), 498e(4) and 498h(5) of the Mental Health Code and completed within three (3) days excluding Sundays and legal holidays after the CEO receives the request.

ii. If the conclusion of the second opinion is different from the conclusion of the original pre-admission screening, the CEO in conjunction with the Medical Director will make a decision based upon all clinical information available within one (1) business day. This decision will be communicated in writing to the individual requesting the second opinion.

iii. 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 SCCMHA's Recipient Rights Officer. The individual requesting the second opinion will be informed of his/her right to file a recipient rights complaint in the written communication containing the denial.

iv. If the initial request for inpatient admission is denied and the individual is a current recipient of other SCCMHA services, the individual or someone on his/her behalf may file a recipient rights complaint alleging a violation of his/her right to treatment suited to condition.

v. If the second opinion determines that the individual is not clinically suitable for hospitalization and the individual is a current recipient of other SCCMHA services and a recipient rights complaint has not been filed previously on behalf of the individual or someone on his/her behalf may file a complaint with the SCCMHA for processing under Chapter 7A of the Mental Health Code.

b. Denial of access to SCCMHA services

i. If an initial applicant for SCCMHA services is denied services, the applicant or his/her guardian, or the applicant's parent in the case of a minor will be informed of their right to request a second opinion from the CEO. The second opinion must be completed by someone of equal or greater credentials to the person completing the initial assessment. The request

will be processed in compliance with Section 705 of the Mental Health Code and must be resolved within five (5) business days.

ii. The applicant 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. He/she may, however, file a rights complaint if the request for a second opinion is denied.

c. Denial of family support subsidy

i. Pursuant to Section 159(3) of the Mental Health Code, if an application for a family support subsidy is denied or a family support subsidy is terminated the parent or legal guardian of the affected eligible minor may demand in writing a hearing by SCCMHA within two (2) months of the notice of denial or termination. 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 Complied Laws.

ii. Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms will be available from the Recipient Rights Officer. Families may be asked to write a letter to SCCMHA requesting an appeal hearing in lieu of a standardized form.

iii. The CEO or designee will review an application and approve or deny the application within ten (10) business days and will provide written notice to the applicant of the action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to insufficient information on the application form or the required attachments, the respondent will identify the insufficiency.

15. Medicaid Fair Hearing Requirements

a. Access to the fair hearing process applies to all Medicaid beneficiaries including those enrolled in the Habilitation and the Supports Waiver for persons with developmental disabilities and the Children's Waiver.

b. Medicaid beneficiaries will be told of their right to an administrative hearing if at any time when an adverse action is taken regarding reduction, suspension or termination of services.

c. Duty to Provide Notice of Action

i. Medicaid beneficiaries will receive notice of their ability to request a hearing with the Michigan Department of Health and Human Services. A Medicaid beneficiary has 90 days from the date of the action notice to make a request for fair hearing. Medicaid beneficiaries can request a local appeal or State Fair Hearing for the following actions:

1. Reduction, suspension or termination of previously authorized services

2. Denial or limit in authorization of a requested service including the type or level of service

3. Denial, in whole or in part, of payment for service

4. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service

5. Failure to make an expedited authorization decision within 3 working days from the date of receipt of a request for expedited service authorization

6. Failure to provide services within 14 calendar days of the start date agreed upon during the person centered planning and as authorized

7. Failure to act within 45 calendar days from the date of a request for a standard appeal

8. Failure to act within 3 working days from the date of a request for an expedited appeal

9. Failure to provide disposition and notice of a local grievance/complaint within 60 calendar days of the date of the request.

Adequate Notice: Required whenever treatment decisions are made to deny Medicaid covered services or whenever the plan of care is developed or modified through the person centered planning process.

1. Adequate notice will be in writing and include:

a. A statement of what action is being taken

b. The reason for the action

c. The legal basis

d. An explanation of the individual's right to request a hearing.

2. Adequate notice is not required to be made in advance of the action and does not provide the individual with a guarantee of continuing services.

Medicaid beneficiaries are provided with written adequate notice of action regarding authorization of service as follows:

1. At the time of the decision to deny payment for a service (on the same date the action takes effect)

2. At the time of the signing of the individual plan of services/supports

3. Within 14 calendar days of the request for a standard service authorization if the decision will deny or limit services

4. Within 3 working days of the request for an expedited service authorization if the decision will deny or limit services

ii. Advance Notice: Notice of an adverse action which is required whenever a decision is made outside the plan of service or person centered planning process to suspend, reduce, or terminate an existing Medicaid service as defined through the plan of service.

1. Advance Notice is not required if a treating professional (professionals who are licensed or certified in the state of Michigan in a human services field typically associated with mental health or development disabilities service) decides that a particular mental health service is not needed.

2. Whenever services are denied, suspended, reduced, or terminated as a result of a utilization review function the agency must notify the provider of the adverse action. The provider has an opportunity to appeal the adverse action, if they elect not to

then the provider will issue an advance notice of adverse action to the affected beneficiary.

3. Advance Notice of adverse action must be given at least ten (10) business days before the date of the action except under the following conditions which required advance notice be mailed not later than the date of the action:

    a. There is factual information confirming the death of the recipient.

    b. The recipient or his/her legal representative provides a clear, signed, written statement that the recipient no longer wishes services or gives information that requires termination or reduction of services and indicates that the recipient understands that this must be the result of supplying the information.

    c. The recipient has been admitted to an institution where he/she is ineligible under Medicaid for further services.

    d. The recipient's whereabouts are unknown and the post office returns SCCMHA's mail directed to him/her indicating no forwarding address.

    e. It is established by fact that the recipient has been accepted for Medicaid by another CMHSP.

    f. A change in the level of medical care is prescribed by the recipient's physician.

4. Advance Notice of adverse Action must include the following:

    a. A statement of what action SCCMHA intends to take

    b. The reasons for the intended action

    c. The specific justification that supports or the change in Federal or State law that requires the action. Basically legal authority 42 CF 440.230(d).

    d. An explanation of:

i. The SCCMHA Informal Dispute Resolution and instructions for filing an appeal

ii. The recipient's right to request a MDHHS fair hearing and the instructions for doing it

iii. In cases of an action based on a change in law the circumstances under which a hearing will be granted.

e. An explanation of under which circumstances an expedited resolution can be requested and instructions for doing it.

f. An explanation that the beneficiary may represent him/herself or use legal counsel, a relative, a friend or other authorized spokesperson.

g. The circumstances under which service will be continued pending resolution of the local appeal and how to request benefits be continued.

h. An explanation of the circumstances under which the Medicaid covered service(s) is to be continued pending the hearing process.

i. The circumstances under which the beneficiary may be required to pay the costs of these services.

5. A Medicaid beneficiary must file within 45 days of the date of the advance notice. The Medicaid beneficiary will receive a written acknowledgement letter of his/her appeal.

6. Maintaining services and supports:

   If SCCMHA mails the advance notice of adverse action as required and the recipient or his/her legal guardian representative request a MDHHS hearing before the date of action in lieu of or in addition to filing an appeal, SCCMHA may not terminate or reduce services until a decision is rendered after the hearing.

SCCMHA must continue Medicaid services previously authorized while the local appeal and/or State fair hearing is pending if:

a. The beneficiary specifically requests to have the services continued.

b. The beneficiary or provider files the appeal timely.

c. The appeal involves the termination, suspension, or reduction or a previously authorized course of treatment.

d. The services were ordered by an authorized provider.

e. The original period covered by the original authorization has not expired.

When SCCMHA continues or reinstates the beneficiary's services while the appeal is pending the services must be continued until one of the following occurs:

a. The beneficiary withdraws the appeal.

b. Twelve (12) calendar days pass after SCCMHA mails the Resolution Notice of the appeal against the beneficiary unless the beneficiary, with the 12 day timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.

c. A State fair hearing office issues a decision adverse to the beneficiary.

d. The time period or service limits of the previously authorized service has been met.

If SCCMHA's action is sustained by the hearing decision SCCMHA may seek reimbursement from the recipient for the cost of any services provided to the recipient during the period of time the appeal was pending up to the individual's ability to pay as determined by the Michigan Mental Health Code.

d. In addition to the fair hearing process above regarding the denial, suspension, reduction, or termination of services for which an advance notice of adverse

action is required for all Medicaid recipients, persons enrolled in the habilitation/supports waiver must receive notice regarding other adverse actions including the denial of the provider or services of choice.

16. Non-Medicaid Recipients; processes for suspensions, reduction, or termination of services

    a. Whenever an existing service or support of existing services are to be suspended, terminated or reduced as a result of the utilization review function, SCCMHA will inform the individual in writing of the change at least ten (10) business days prior to the effective date of the action. The notice will include:

        i. A statement of what action will be taken

        ii. The reasons for the intended action

        iii. The specific justification for the intended action

        iv. An explanation of the LDRP

    Actions taken as a result of the person centered planning process or those ordered by a physician are not considered an adverse action.

    b. In the event that the individual uses the LDRP or the second opinion processes as described above, SCCMHA will communicate in writing the outcome of that process to the individual. That communication will include notification to the individual of his/her ability to request access to the MDHHS Alternative Dispute Resolution Process.

    c. Access to the MDHHS process does not require agreement by both parties, but may be initiated solely by the consumer.

    The individual has ten (10) days from the written notice of the LDRP outcome within which to request access to the MDHHS Alternative Dispute Resolution Process.

References

PA 516 of 1996
PA 258 of 1974, as amended
S.353-Health Insurance Bill of Rights of 1997
43 CFR Chapter IV, Subpart E, Sections 431.200 et seq.
DCH MSA Policy Bulletin: Medicaid Eligibility Manual-Beneficiary Hearings

Compliance

Internal: Service to Consumers with Limited English Proficiency Policy
SCCMHA Utilization Management Plan

External: Michigan Mental Health Code, Public Act 258 of 1974 as amended, Sec. 100b, 409(4), 705
Code of Federal Regulation - 42CFR434.32, 42CFR431.200-431.246, 42CFR440.230
Balanced Budget Act
DCH Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings
DCH Master Contract Attachments - 3.4.1.1 Person Centered Planning Best Practice Guideline; 3.3.1 Medical Necessity Criteria; P6.3.2.1 Appeal and Grievance Technical Requirement, C6.3.2.1 CMHSP Local Dispute Resolution Process
Family Support Subsidy Act, Public Act 249 of 1983, as amended
Administrative Procedures Act of 1969, Public Act 306 of 1969, Sec. 24.271-24.287
MDHHS Administrative Rules
MDHHS Policy Hearing Authority Decision #01-0358CMH, and subsequent MDHHS clarifications
MDHHS, General Administration, Administrative Hearings - Policy and Procedure, pp.1-56

Approved by: _____ 9-22-2016
Board Chairperson — Date

_____ 9/26/16
Chief Executive Officer — Date

Review/Revision Dates:

Date:	By:
5/15/05, 11/29/06	Revised
1999-2008	Reviewed by Board
4/2/09	New formatting
7/21/11	Reviewed by Recipient Rights Advisory Committee
5/21/12	Revised by Dirk Love and approved by the Board
7/19/12	Reviewed by the Recipient Rights Advisory Committee
10/25/12	Revised by Craig Hause
10/17/13	Reviewed by Recipient Rights Advisory Committee
12/11/14	Reviewed by Recipient Rights Advisory Committee
12/14/15	Revised by Dirk Love
12/14/15	Reviewed by Customer Services
05/06/2016	Policy Statement and Procedure revised by Dirk Love