

# **STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH**

## **ADMINISTRATIVE HEARING PAMPHLET**

This replaces the March 5, 2005, version in its entirety.

This document is neither intended nor shall it be construed as the State Office of Administrative Hearings and Rules (SOAHR) or the Department of Community Health's (DCH) regulation, statement, standard, policy, ruling, or instruction of general applicability that implements or applies law enforced or administered by State Office of Administrative Hearings and Rules or the Department of Community Health, or that prescribes the organization, procedure, or practice of the State Office of Administrative Hearings and Rules or the Department of Community Health, including the amendment, suspension, or rescission of the law enforced or administered by the State Office of Administrative Hearings and Rules or the Department of Community Health.

### **QUESTIONS**

Questions should be directed to the State Office of Administrative Hearings and Rules for the Department of Community Health, P.O. Box 30763, Lansing, Michigan 48909, or by telephone at 1-877-833-0870.

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## **100 How to Contact SOAHR/DCH**

Address: PO Box 30763  
Lansing, MI 48909

Telephone: (877) 833-0870  
(517) 334-9500

Facsimile: (517) 334-9505

E-Mail: [administrativetribunal@michigan.gov](mailto:administrativetribunal@michigan.gov)

## **110 Statement and Purpose**

The State Office of Administrative Hearings and Rules (SOAHR) for the Department of Community Health (DCH) hears a wide variety of appeals of administrative decisions from DCH and DCH contract agencies. The Administrative Law Judges (ALJ) of the State Office of Administrative Hearings and Rules for the Department of Community Health are delegated by the Director of the DCH to hold hearings in accordance with the Administrative Procedures Act, the Social Welfare Act, the Public Health Code, Mental Health Code, the Administrative Code, Social Security Act and its regulations and/or other federal codes.

The information contained in this transmittal is intended to provide information regarding the hearings process and to provide as much uniformity of practice and procedures as current laws and regulations permit. It is to be used to provide information regarding the relevant laws and regulations, not in place of them.

## **120 Legal Authority**

MCL 24.287, 330.1236, 330.1238, 330.1407, 330.1536, 333.20161, 333.20168, 333.20958, 333.21774, 333.21799a, 400.1 et seq., 400.9; 7 CFR 246.1 et seq.; 42 CFR 431.200 et seq., 42 CFR 438 et seq. 42 CFR 488.335, and Michigan Administrative Code Rule 330.2052 and Rule 400.919.

## 130 Definitions

### Action:

- Termination, suspension, reduction or denial of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Social Security Act;
- **For Medicaid Recipients of Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP):** A decision that adversely impacts a Medicaid beneficiary's claim for services due to:
  - Denial or limited authorization of a requested service, including the type or level of service.
  - Reduction, suspension, or termination of a previously authorized service.
  - Denial, in whole or in part, of payment for a service.
  - Failure to make a standard authorization decision and provide notice about the decision with **14 calendar days** from the date of receipt of a standard request for service.
  - Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
  - Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP/MCO.
  - Failure of the PIHP/MCO to act within **45 calendar days** from the date of a request for standard appeal.
  - Failure of the PIHP/MCO to act within **three (3) working days** from the date of a request for an expedited appeal.
  - Failure of the PIHP/MCO to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

**Additional Mental Health Services:** Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as “**B3**” waiver services.

**Adequate Notice of Action:** Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested**. Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

**Administrative Hearing:** An impartial review of a decision made by the Department of Community Health (DCH) or one of its contract agencies presided over by a SOAHR/DCH Administrative Law Judge.

**Administrative Law Judge (ALJ):** A person designated by SOAHR/DCH to conduct hearings in an impartial and unbiased manner.

**Advance Notice of Action:** Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

**Adverse Action:** Includes but is not limited to:

Women, Infants, and Children Program (WIC):

- (i) Denial of the vendor's application for authorization based on the vendor selection criteria for competitive price or for minimum variety and quantity of authorized supplement foods or on a determination that the vendor is attempting to circumvent a sanction.
- (ii) Termination of an agreement for cause.
- (iii) Disqualification from the WIC program.
- (iv) Imposition of a fine or civil money penalty in lieu of disqualification.

Medicaid Provider:

- (i) A suspension or termination of provider participation in the medical assistance program.
- (ii) A denial of an applicant's request for participation in the medical assistance program.
- (iii) A denial, revocation, or suspension of a license or certification issued by the Department to allow a facility to operate.
- (iv) The reduction, suspension, or adjustment of provider payments.
- (v) Retroactive adjustments following the audit or review and determination of the daily reimbursement rates for institutional providers.

Adult Benefit Waiver:

A discontinuation, termination, suspension or reduction of adult benefit services.

**Adverse Determination:** A determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7) of the Social Security Act that the individual does not require the level of services provided by the nursing facility or that the individual does or does not require specialized services.

**Appeal:** Request for a review of an “action.”

**Appellant:** A beneficiary, resident, patient, consumer or responsible party requesting a hearing.

**Authorization of Services:** The processing of requests for initial and continuing service delivery.

**Authorized Hearing Representative (AHR):** - A person, legally designated, to stand in for, or represent the Appellant in the hearing process.

**Beneficiary:** An individual who has been determined eligible for Medicaid.

**Contested Case:** A proceeding under the Michigan Administrative Procedures Act in which a determination of the legal rights, duties, or privileges of a named party is required by law to be made by an agency after an opportunity for an evidentiary hearing.

**Date of Action:** The date on which a termination, suspension, reduction, transfer or discharge become effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review (PASARR) requirements of section 1919(e)(7) of the Act.

**DCH Contract Agency:** Any agency or organization that has contracted with the Department that either determines eligibility for a Department program, or delivers a service provided under a Department program to a beneficiary, patient, or resident.

**Department Contact:** The individual in a substantive area identified as responsible for the decision for which the hearing is being held.

**Department Representative:** A DCH or DCH Contracted Agency staff person assigned to serve as the liaison between the agency or DCH organization and the State Office of Administrative Hearings and Rules for the Department of Community Health.

**Expedited Hearing:** A hearing that is held within three (3) workdays after receipt of hearing request because a delay in conducting the hearing would seriously jeopardize the life or health of the Medicaid beneficiary or would jeopardize his/her ability to attain, maintain or regain maximum function.

**Expedited Local Appeal:** The expeditious review of an action, requested by a managed care beneficiary or the beneficiary's provider when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP/MCO determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP/MCO must grant the request.

**Fair Hearing:** An impartial review of a decision made by the Department of Community Health (DCH) or one of its contract agencies presided over by a SOAHR/DCH Administrative Law Judge.

**Final Determination Notice:** A notice of an adverse action for Medicaid enrolled providers which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule, or guideline under which the action is taken; and the right to a hearing.

**Grievance:** Medicaid beneficiary's expression of dissatisfaction about PIHP/MCO service issues, **other than an action**. Possible subjects for grievances included, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

**Grievance Process:** Impartial local level review of Medicaid beneficiary's grievance (expression of dissatisfaction) about PIHP/CHMSP/MCO service issues **other than an action**.

**Grievance System:** Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

**HIPAA:** Health Insurance Portability and Accountability Act.

**Local Appeal Process:** Impartial local level PIHP/MCO review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

**Managed Care Organization (MCO):** An entity that has, or is seeking to qualify for a comprehensive risk contract under this part, and that is:

- (1) A Federally qualified HMO that meets the advance directive requirements of subpart I of part 489 of this chapter; or
- (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
  - (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.
  - (ii) Meets the solvency standards of §438.116.  
*42 CFR 438.2*

**Medicaid Services:** Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Supports waiver, Children's Waiver, MIChoice Waiver and/or Section 1915(b)(3) of the Social Security Act.

**Mental Health Financial:** the ability of a responsible party to pay for the cost of mental health services.

**Mental Health Transfer:** a resident in a state facility may be transferred to any other center, or to a hospital operated by the Department, if the transfer would not be detrimental to the resident and the responsible community mental health services program approves the transfer.

**Notice of Disposition:** Written statement of the PIHP/MCO decision for each local appeal and/or grievance provided to the beneficiary.

**Program of all-inclusive care for the elderly (PACE):** Provides pre-paid, capitated comprehensive health care services to frail, older adults.

**Prepaid Inpatient Health Plan (PIHP) –** An entity that:

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use the State plan payment rates;
2. Provides, arranged for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
3. Does not have a comprehensive risk contract.

## 200 Grievance System General Requirements for Medicaid Managed Care Beneficiaries

Federal regulations (42 CFR 438.200 *et seq.*) requires the state to ensure through its contracts with PIHP/MCOs, that each PIHP/MCO has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP/MCO appeal process for challenging an “action” taken by the PIHP/MCO or one of its agents.
- Access to the state level fair hearing process for an appeal of an “action”.
- A local PIHP/MCO grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an “action”.
- The right to **concurrently** file a PIHP/MCO level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP/MCO level grievance regarding other services complaints.
- The right to request a State fair hearing **before exhausting** the PIHP/MCO level appeal of an “action”.
- The right to request, and have, Medicaid benefit continued while a local PIHP/MCO appeal and/or State fair hearing is pending.
- The right to have a provider, acting on the beneficiary’s behalf and with the beneficiary’s written consent, file an appeal to the PIHP/MCO. The provider may file a grievance or request for a State fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary’s authorized representative in doing so.

## 210 Service Authorization Decisions for Medicaid Managed Care Beneficiaries or Applicants

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP/MCO **must provide** the beneficiary a written service authorization decision within specified timeframes and as expeditiously as the beneficiary’s health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization**: Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service, with a possible extension of **14 additional calendar days** if the beneficiary or provider requests an extension **OR** if the PIHP/MCO justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest.
- **Expedited Authorization**: In cases in which a provider indicates, or the PIHP/MCO determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP/MCO must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP/MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP/MCO may extend the three working day time period by up to **14 calendar days**.

When a **standard or expedited** authorization of services decision is extended, the PIHP/MCO must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP/MCO must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

## **300 Notices of Action**

### **A. Medicaid beneficiaries (including PACE Enrollees)**

There are two (2) types of Notice of Action:

**Adequate notice** and **Advance notice**

Adequate notices are sent on the effective date of the action. An adequate notice is used for a denial of requested service or a denial of a new authorization.

Advance notice must be mailed at least 12 days before the proposed effective date. An advance notice is used for termination, suspension, or reduction of a Medicaid service. A DCH-0092, Hearing Request Form (Exhibit I) or its equivalent shall be sent to the appellant with all adequate and advance notices.

The client must be sent a written notice at the time of **each “action”**.

1. An adequate notice must contain:

- A statement of what action is being taken by the DCH or any contract agency or nursing facility;
- The reasons for the intended action;
- The specific regulations that support the action;
- Explanation of the individual’s right to request a fair hearing and instructions for doing so;
- An explanation that the beneficiary may represent himself/herself or use legal counsel, a relative , a friend or other spokesperson.

2. An advance notice must also contain:

- The circumstances under which services will be continued pending resolution of the appeal;
- How to request that benefit be continued; and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

3. Limited exceptions to the advance notice requirement.

The DCH/DCH contract agent may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The DCH/DCH contract agent has factual information confirming the death of the beneficiary.
- The DCH/DCH contract agent receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.

- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns DCH/DCH contract agent mail directed to him/her indicating no forwarding address.
- The DCH/DCH contract agent establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician.
- The date of the action will occur in less than **12 calendar days**.

4. Medicaid services are to be continued during the pendency of the State fair hearing **if:**

- The beneficiary specifically requests to have the services continued, and
- The beneficiary files the appeal within 12 days of the date on the notice, and
- The appeal involves the termination, suspension or reduction of a previously authorized service, and
- The original period covered by the original authorization has not expired.

5. Medicaid services are continued or reinstated while an appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- An Administrative Law Judge orders a decision which is adverse to the beneficiary.
- The time period or service limits of the previously authorized service has been met.

**Exception:** Do not provide a notice when you are implementing a hearing decision or a policy hearing authority decision. The hearing decision serves as notice of the action.

## **B. Medicaid Managed Care Beneficiaries Notice State Fair Hearings**

Medicaid beneficiaries served by PIHP/MCOs have additional rights provided by federal regulations at 42 CFR 438 et seq.

**The content of both adequate and advance notices must include an explanation of:**

- What action the PIHP/MCO has taken or intends to take.
- The reason(s) for the action.
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
- The beneficiary's or provider's right to file a PIHP/MCO appeal, and instructions for doing so.
- The beneficiary's right to request a State fair hearing, and instructions for doing so.
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself/herself or use legal counsel, a relative, a friend or other spokesperson.

**The content of an advance notice must also include an explanation of:**

- The circumstances under which services will be continued pending resolution of the appeal,
- How to request that benefit be continued, and
- The circumstances under which the beneficiary may be required to repay the costs of these services.

And:

- The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP/MCO to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.

**Service Authorization decisions will:**

Constitute an “**action**” if the service authorized is less in amount, duration or scope than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP/MCO **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP/MCO has taken, or intends to take and the process available to appeal the decision.

**Notices must be mailed:**

- **At least 12 calendar days before** the date of an action to terminate, suspend or reduce previously authorized Medicaid covered service(s) (Advance).
- **At the time of the decision** to deny payment for a service to deny a newly requested service (Adequate).
- **Within 14 calendar days** of the request for standard service authorization decision to deny or limit services (Adequate).
- **Within three (3) working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

**C. Pre-Admission Screening and Annual Resident Review (PASARR, also known as OBRA)**

Notices of actions or adverse determinations for PASARR recipients **also** must comply with the following notice requirements:

- Is a nursing facility level of services needed?
- Are specialized services needed?

- The placement options that are available to the individual consistent with these determinations; and
- The rights of the individual to appeal the determination.

**D. Adult Benefit Waiver**

There are two types of written notices – **timely and adequate**.

- **Timely Notice**  
A timely notice is mailed with the proposed change at least ten days before the action would become effective.
- **Adequate Notice**  
An adequate notice is mailed with the proposed change no later than the date upon which the action would become effective.

See Section A (Medicaid Beneficiaries) for Notice Requirements.

**E. Women, Infants, and Children (WIC) Participant**

At the time of a claim against an individual for improperly issued benefits or at the time of participation denial or of disqualification from the Program, the local agency shall inform each individual in writing of the right to a local level hearing, of the method by which a local level hearing may be requested, and that any positions or arguments on behalf of the individual may be presented personally or by a representative such as a relative, friend, legal counsel or other spokesperson. Such notification is not required at the expiration of a certification period.

A local level hearing will be held. The local level hearing decision must include a notice of the Appellant's right to request a hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health, the time limit for requesting a hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health and the address and phone number of the State Office of Administrative Hearings and Rules for the Department of Community Health.

## **F. Women, Infants, and Children (WIC) Vendor**

1. The Department shall provide to the vendor written notification of the adverse action that includes: (1) the procedures to follow to obtain an administrative hearing; (2) the reasons for the adverse action; (3) the effective date of the adverse action, if applicable.
2. Notification of the adverse action shall be mailed to a vendor at least 21 calendar days in advance of the effective date of action except as provided in Section 200 below for 15-day Termination Orders.
3. The effective date of the termination and permanent disqualification of a vendor as the result of a conviction of the vendor for trafficking in food instruments or selling firearms, ammunition, explosives, or controlled substances (as defined in Section 102 of the Controlled Substance Act – 21 USC 802) in exchange for food instruments shall be on the date of receipt of the notice of adverse action by the vendor. A vendor shall not be entitled to receive any compensation for revenues lost as a result of such termination and disqualification.
4. Except as provided in paragraph C above and in Section 7 below, a vendor who has timely appealed an adverse action by the Department may be allowed to remain on the WIC Program until the effective date of the final order or the contract expires, whichever occurs first. An appeal shall not require that the Department enter into a new contract with the vendor after expiration of the current contract.

## **400 Hearing Requests and Deadlines for Hearing Requests**

### **A. All Programs**

All requests for a hearing must be in writing. The hearing request should provide the name, address and telephone number of the person for whom the hearing is being requested. The name, address, and telephone number of the person requesting the hearing, if different, should be included. The benefit or program involved should be clearly identified. The hearing request should identify what decision is being challenged.

The State Office of Administrative Hearings and Rules for the Department of Community Health will deny hearing requests signed by unauthorized persons and requests without original signatures.

#### **B. Medicaid Beneficiaries and Adults Benefit Waiver Beneficiaries**

The beneficiary or authorized hearing representative has 90 calendar days from the date of the written notice of action to request a hearing. The written hearing request must be received within the 90-day period by the State of Michigan.

#### **C. Lead Abatement**

The request for a hearing must be made in writing, no later than 15 working days after receipt of a citation or notice of revocation or suspension of accreditation or certification.

#### **D. Medicaid Managed Care Beneficiaries Local Level Appeal**

Medicaid beneficiaries participating in managed care are **NOT** required to exhaust MCO and PIHP level appeals before they request a hearing. Medicaid managed care beneficiaries may process simultaneous appeals.

#### **E. Mental Health Transfers**

An appeal of a non-emergency transfer may be made at any time before the transfer. An appeal of an emergency transfer may be made up to seven (7) days after the transfer.

#### **F. Mental Health Financial**

The individual or Authorized Hearing Representative may appeal a determination of financial liability made by the Department within 30 days of the date the determination was given or mailed to the individual, spouse, or parent.

#### **G. Medicaid Provider**

**This section applies only to Medicaid enrolled providers**

Any provider participating, or applicant wishing to participate in the Medicaid Program may appeal an adverse action taken by the DCH.

Medicaid provider hearings are governed by Social Welfare Act (MCL 400.1 et seq.) and 1979 AC, R 400.3401 through 400.3425

## **H. Certificate of Need (CON)**

Certificate of Need hearings are governed by the Public Health Code and 1986 AACRS, R 325.9101 et seq.

A request for a hearing shall be filed within 15 days of the applicant's receipt of the Department's proposed decision or receipt of notice of reversal by the director of a proposed decision that is an approval.

## **I. Women, Infants, and Children (WIC) Vendor**

### **Request for Hearing**

1. An appeal is initiated by filing a request for an administrative hearing with the Department. The request shall be addressed to:

State Office of Administrative Hearings and Rules  
for the Department of Community Health  
P.O. Box 30763  
Lansing, MI 48909

2. A request for an administrative hearing shall be made in writing and shall include a statement of the facts asserted, the relief sought, and if the vendor is represented by legal counsel, the name, address and telephone number of the attorney.
3. The Department must receive a request for an administrative hearing within 21 calendar days of the date of mailing of the adverse action notice to the Appellant. Any request for an administrative hearing received later than 21 days after the date of mailing of the adverse action notice is untimely and an administrative hearing will not be conducted.

### **15-Day Termination Orders**

1. Upon a finding that the vendor has violated its contract, the regulatory or statutory provisions governing the WIC Program or the State Plan of Program Operation and Administration approved by the United States Department of Agriculture which seriously affect the public health, safety or welfare or the integrity of the WIC Program, the Department may issue an order terminating a vendor's WIC contract effective 15 days from the date of service of the order. The order shall incorporate the Department's findings.

2. Upon issuance of a 15-Day Termination Order, the Department shall provide the vendor with an opportunity for a hearing within five business days after the service of the Order. "Business day" means a day of the year, exclusive of a Saturday, Sunday or a State holiday. The hearing date, time and location shall be specified in the 15-Day Termination Order. Except as modified by this section, the hearing shall be conducted in accordance with these Administrative Hearing Procedures for Vendors.
3. The conduct of a hearing under this section shall not suspend the effectiveness of the Department's 15-Day Termination Order.
4. A 15-Day Termination Order may include sanctions in addition to contract termination, such as disqualification of the vendor from the WIC Program.

#### **J. Women, Infants, and Children (WIC) Participant**

The Appellant may appeal a local-level WIC hearing decision to the State Office of Administrative Hearings and Rules for the Department of Community Health, provided that the request for appeal is made within 15 days of the mailing date of the local-level hearing decision notice.

### **410 Filing the Request for Hearing**

#### **All Programs**

All hearing requests should be mailed to:

State Office of Administrative Hearings and Rules  
for the Department of Community Health  
P.O. Box 30763  
Lansing, MI 48909

If a hearing request is received in another location, a copy of the request should immediately be faxed to the State Office of Administrative Hearings and Rules for the Department of Community Health at (517) 334-9505. The original request should be forwarded to the State Office of Administrative Hearings and Rules for the Department of Community Health within seven (7) days.

## **420 Request for Expedited Hearings**

Expedited hearings may be granted by the State Office of Administrative Hearings and Rules for the Department of Community Health. The client, authorized representative or Department may call the State Office of Administrative Hearings and Rules for the Department of Community Health at its toll-free number to request an expedited hearing.

## **430 Processing Hearing Requests**

### **Medicaid Beneficiaries; Mental Health Financial; WIC Participant; Adult Benefit Waiver Beneficiaries**

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the Department Representative. The purpose of this fax copy of the hearing request is to alert the Department Representative that a request for hearing has been filed and to allow the Department Representative to begin to prepare for a hearing and/or settle the case.

### **Lead Abatement**

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the Lead Hazard Remediation Program. The Program shall file with the State Office of Administrative Hearings and Rules for the Department of Community Health a copy of its notice and/or citation and supporting documentation within 14 days.

### **Medicaid Provider**

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the designated Department Representative. The Appeals Section shall file with the State Office of Administrative Hearings and Rules for the Department of Community Health, within 30 days after receipt by the Department of the hearing request, a copy of the final determination notice and supporting documentation.

### **Mental Health Transfer**

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the facility transfer coordinator. The transfer coordinator is responsible for faxing the transfer order and written Community Mental Health approval to the State Office of Administrative Hearings and Rules for the Department of Community Health no later than the day before the hearing.

### **Certificate of Need**

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to Certificate of Need (CON) Program office. The CON office must file with the State Office of Administrative Hearings and Rules for the Department of Community Health a copy of its notice to the Applicant and supporting documentation within 14 days.

### **Women, Infants, and Children (WIC) Vendor**

- A. Following timely receipt of a written request for an administrative hearing, the Department shall provide the vendor with an opportunity for a hearing at the offices of the Michigan Department of Community Health.
- B. Notification of the hearing shall be sent certified mail and shall include: the time and location of the hearing.
- C. The notice of hearing must be mailed at least ten (10) calendar days prior to the scheduled administrative hearing date.

### **Involuntary Transfer of Discharge from a Nursing Facility**

Upon receipt of a request for hearing the State Office of Administrative Hearings and Rules for the Department of Community Health will schedule an informal hearing no sooner than seven (7) days after the request for hearing is received, but no later than 14 days.

## **440 Denial of Request for Hearing**

### **All Programs**

Only the State Office of Administrative Hearings and Rules for the Department of Community Health may deny a request for a hearing. All hearing requests shall be forwarded to the State Office of Administrative Hearings and Rules for the Department of Community Health (refer to Section **400** of this policy).

### **Medicaid Beneficiary; Mental Health Financial; Mental Health Transfer; WIC Participant, Adult Benefit Waiver Beneficiaries**

If the Department or its contract agent believes the State Office of Administrative Hearings and Rules for the Department of Community Health has no jurisdiction to hold a hearing, fax or mail a statement to the State Office of Administrative Hearings and Rules for the Department of Community Health explaining what it is believed to be the legal basis for not granting a hearing.

The State Office of Administrative Hearings and Rules for the Department of Community Health will inform the appellant, the AHR and the Department Representative.

### **Lead Abatement; Medicaid Provider; Certificate of Need; WIC Vendor**

If you believe a request is inappropriate or if the request was filed beyond the required deadline a motion for a hearing denial may be made. To request a hearing denial:

- Prepare a memorandum stating:
  - Why the request should not be heard; or
  - The request was received after the required deadline for filing a hearing request (attach a copy of the notice); and
- Forward the hearing request and memorandum to the State Office of Administrative Hearings and Rules for the Department of Community Health.

- The State Office of Administrative Hearings and Rules for the Department of Community Health will inform the Appellant and Department if the request is denied.

## **500 Notice of Hearing**

**Medicaid Beneficiary and Providers; Certificate of Need; Emergency Medical Personnel; Emergency Medical Services; and Health Systems for hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code.**

The Notice of Hearing will include a docket number, which is an identifier for each hearing.

Notice of the time, date, and place of hearing shall be mailed to the parties, or their authorized hearing representative.

### **Involuntary Transfer or Discharge from a Nursing Facility**

Notice of the time, date and place of hearing will be mailed or faxed to the parties.

## **510 Place of the Hearing**

**Medicaid Beneficiaries; Mental Health Financial; WIC Participant; Adult Benefit Waiver Beneficiaries**

Hearings are routinely scheduled for telephone conference calls. The Administrative Law Judge conducts the hearing from his/her office. The ALJ will call the Appellant/AHR at the number provided on the Hearing Request form.

The Appellant/AHR may request permission of the State Office of Administrative Hearings and Rules for the Department of Community Health to appear by phone from another location. The request must be made to the State Office of Administrative Hearings and Rules for the Department of Community Health at least one full business day before the hearing.

For Medicaid Beneficiaries and Adult Benefit Waiver Beneficiaries the Appellant/AHR may request that the hearing be conducted in person with the ALJ. The ALJ will travel to the local office, facility, Community Mental Health Services Program office, Area Agency on Aging office or other identified location on the scheduled hearing date.

**Lead Abatement; Medicaid Provider; Certificate of Need (CON); Emergency Medical Personnel; Emergency Medical Services; Health Systems; Women, Infants, and Children (WIC) Vendor**

Hearings are conducted in the hearing rooms of the Department in Lansing. Occasionally, the State Office of Administrative Hearings and Rules for the Department of Community Health will conduct hearings in other locations at the discretion of the State Office of Administrative Hearings and Rules for the Department of Community Health.

**Mental Health Transfer**

All hearings are conducted by telephone conference call.

**Involuntary Transfer**

Hearings are conducted by telephone after concurrence of the appellant.

**520 Appearances**

**All Programs**

An Appellant may appear on his or her own behalf.

An Appellant may have an attorney appear on his/her behalf. The attorney must file a written Appearance with the State Office of Administrative Hearings and Rules for the Department of Community Health at least two (2) days before the scheduled hearing.

DCH or its contract agencies may appear through designated staff or attorneys.

**Medicaid Beneficiaries and Adult Benefit Waiver Beneficiaries**

An Appellant may be represented by an authorized hearing representative (AHR).

The right to be an AHR comes from one of the following sources:

- Written authorization signed by the appellant, giving a person the authority to act for the appellant in the hearing process,
- Court appointed guardian or conservator,

- Legal parent of a minor child,
- An AHR has no right to a hearing, but rather exercises the appellant's right.

## 530 Adjournments

### **Medicaid Beneficiaries; Medicaid Providers; Mental Health Financial; Mental Health Transfer; WIC Participant; Adult Benefit Waiver Beneficiaries**

The Appellant/AHR or Department may request an adjournment (also called a postponement) of a scheduled hearing for good cause. **Only the State Office of Administrative Hearings and Rules for the Department of Community Health can grant or deny a request for an adjournment.**

### **Emergency Medical Personnel; Certificate of Need; Health Systems for hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code.**

A party may request an adjournment of a scheduled hearing by motion to the Administrative Law Judge assigned to conduct the hearing. The presiding ALJ will not rule on the motion until the opposing party has an opportunity to be heard on the request. If all parties agree to the adjournment, the ALJ may rule on the request immediately.

### **Women, Infants, and Children (WIC) Vendor**

One opportunity shall be provided to both the Department and the vendor to reschedule the hearing date upon specific request in writing addressed to the Administrative Law Judge. Any further requests for adjournment of the hearing must be by motion and addressed to the Administrative Law Judge and shall be granted only upon a showing of good cause. The Administrative Law Judge shall not rule on the request for adjournment until all parties have had an opportunity to be heard on the request. However, if all parties agree to an adjournment, then the Administrative Law Judge may be so advised by telephone and may rule on the request immediately.

## 540 New Applications or Requests for Services

### **Medicaid Beneficiaries**

A new application or request for services should not be delayed while a hearing is pending on a previous determination. Process the application or request and notify the beneficiary of your determination, following all

Department policies and procedures. Advise the State Office of Administrative Hearings and Rules for the Department of Community Health if the new determination makes the previously requested hearing unnecessary.

## **550 Department Representative and Department Contact**

Each substantive area or component involved in hearings with the State Office of Administrative Hearings and Rules for the Department of Community Health is required to designate a Department Representative.

Hearing requests received by the State Office of Administrative Hearings and Rules for the Department of Community Health will be faxed to the Department Representative. If there is a change in date or location, the Department Representative will be contacted. The Department Representative will be sent all notices and orders issued by the State Office of Administrative Hearings and Rules for the Department of Community Health.

The purpose of the Department Representative is to serve as a single contact point for the State Office of Administrative Hearings and Rules for the Department of Community Health to communicate regarding procedural aspects of any case. The individual presenting the case to the ALJ is the Department Representative. It is their responsibility to ensure the faxes and papers reach the proper persons.

The Department Contact is the individual in a substantive area identified as responsible for the decision for which the hearing is being held. A copy of the decision and order is mailed to the Department Contact. Any problems arising out of the hearings is directed to the Department Contact.

It is the responsibility of the substantive organization to contact the State Office of Administrative Hearings and Rules for the Department of Community Health with any changes in Department Representatives and/or Department Contacts and to ensure that the State Office of Administrative Hearings and Rules for the Department of Community Health has the proper name of individuals (Department Representative and Department Contact); the correct fax number; phone numbers and addresses for the organization which has taken the action and/or has oversight responsibility for contract agencies.

## **560 Hearing Summary**

A Hearing Summary (Exhibit II) or its equivalent shall be prepared for each hearing: Adult Benefit Waiver, Breast & Cervical Cancer Prevention, Children's Special Health Care Services, Medicaid Client general issue, Community Mental Health, Disenrollment, Elderly & Disabled Waiver, Habilitation & Supports Waiver, Home

Help Services, Medicare Buy-In, Managed Care Exception, Mental Health Financial, Mental Health Transfer, Medical Services Billing, OBRA/PASARR, Office of Medical Affairs, Prior Authorization, First Health Pharmacy, Qualified Health Plan, Substance Abuse Services and Transportation.

The narrative must include all of the following:

- Clear statement of the action and/or decision being appealed, including all programs involved in the action.
- Facts that led to the action, or decision.
- Policy which support the action, or decision.
- Correct address of the Appellant or AHR.
- Description of the documents the DCH or the DCH Contract Agency intends to offer as exhibits at the hearing.

A copy of the hearing summary and all documents and records to be used by DCH or the DCH Contract Agency at the hearing must be mailed to the Appellant and/or AHR and the State Office of Administrative Hearings and Rules for the Department of Community Health **at least seven (7) calendar days before the scheduled hearing.**

**Appellants and AHR's have the right to review the case record and obtain copies of documents and materials relevant to the hearing.**

## **570 Pleadings**

### **Certificate of Need**

All pleadings must comply with 1996 AACS, R 325.9507 and 9509

### **Emergency Medical Personnel**

All pleadings must comply with 2004 AACS, R 325.22351  
All answers must comply with 2004 AACS, R 325.22353

### **Health Systems**

For hearings required by Sections 20165, 20166, 20168, 21799(10),

21799b(2), and 21799c of the Public Health Code

All pleadings must comply with 1981 AACS, R 325.21908.

All answers must comply with 1981 AACS, R 325.21910

### **Medicaid Providers**

All pleadings must comply with 1979 AC, R 400.3412

### **Women, Infant & Children (WIC) Vendor**

All pleadings must be in writing, and contain the vendor's name and vendor number, if any.

## **580 Withdrawal**

### **Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfers; WIC Participant; Adult Benefit Waiver Beneficiaries; Lead Abatement; WIC Vendor**

At any time before a final decision is issued, an appellant may withdraw its application or request for a hearing. The withdrawal must be in writing or on the record.

Do not ask for a withdrawal that is based on an action you plan to take in the future. If the DCH/DCH Contract Agency settles the case before the hearing:

- Notify the State Office of Administrative Hearings and Rules for the Department of Community Health that the disputed action has been corrected and that the appellant's concerns have been resolved.

When any issue is still in dispute, do not:

- Suggest that the Appellant or AHR withdraw the request;  
or
- Mail a withdrawal form to the Appellant or AHR unless requested.

Do not ask for a withdrawal that is based on an action you plan to take in the future.

An Appellant or AHR may agree to withdraw the hearing request at anytime during the hearing process. Instruct the Appellant or AHR to fill out the Hearing Request Withdrawal form (DCH-0093, See Exhibit IV) and return it immediately in the postage paid envelope to the State Office of Administrative Hearings and Rules for the Department of Community Health or fax it to (517) 334-9505.

**Medicaid Provider; Certificate of Need; Emergency Medical Personnel; Emergency Medical Services; Health Systems hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code.**

At any time before the Director of the Department of Community Health issues a final decision, a party may withdraw its request for a hearing. The withdrawal must be in writing or on the record.

## **590 Dismissal**

**Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfers; WIC Participant; Adult Benefit Waiver Beneficiaries**

The State Office of Administrative Hearings and Rules for the Department of Community Health may dismiss a request for a hearing if the Appellant/AHR fails to appear at a scheduled hearing without good cause.

**Emergency Medical Personnel, Emergency Medical Services; Health Systems; Lead Abatement; Medicaid Provider; Certificate of Need; WIC Vendor**

An Appellant who fails to appear at the scheduled hearing, or fails to comply with Prehearing orders, waives the right to an administrative hearing and any other review to which he or she might be entitled, and such waiver shall constitute acceptance of the action the Department took or proposes to take. The hearing request will be dismissed.

## **600 Local Level Appeals (Medicaid Managed Care & PACE)**

### **A. Medicaid Managed Care Beneficiaries**

- Medicaid beneficiaries participating in managed care are NOT required to exhaust MCO and PIHP level appeals before they request a hearing. Medicaid beneficiaries may process simultaneous appeals.
- Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP/MCO appeals, like those for fair hearings, are initiated by an “action”. The beneficiary may request a local appeal under the following conditions:
  - The beneficiary has 45 **calendar days** from the date of the notice of action to request a local appeal.

- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
- The beneficiary may file an appeal with the PIHP/MCO organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than **12 calendar days** from the date of the action, the PIHP/MCO must reinstate the Medicaid services until disposition of the hearing.

**When a beneficiary requests a local appeal, the PIHP/MCO is required to:**

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
- Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP/MCO Quality Improvement Program.
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professions with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- Provide the beneficiary, or representative with:
  - Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
  - Opportunity, before and during the appeal process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process.
  - Opportunity to include as parties to the appeal the beneficiary and his/her representative or the legal representative of a deceased beneficiary's estate.

- Information regarding the right to a fair hearing and the process to be used to request the hearing.

**Notice of Disposition requirements:**

- The PIHP/MCO must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution.
- The content of a notice of disposition must include explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
  - The right to request a State fair hearing, and how to do so;
  - The right to request to receive benefits while the State fair hearing is pending, if requested with 12 days of the mailing of the PIHP/MCO notice of disposition, and how to make the request; and
  - That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP/MCO's action.

**The Notice of Disposition must be provided within the following timeframes:**

- **Standard Resolution:** The PIHP/MCO must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP/MCO receives the appeal.
- **Expedited Resolution:** The PIHP/MCO must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working days** after the PIHP/MCO receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP/MCO determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

- The PIHP/MCO may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- If the PIHP/MCO denies a request for expedited resolution of an appeal, it must:
  - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP/MCO receives the appeal;
  - Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
  - Give the beneficiary follow up **written notice** within **two (2) calendar days**.
- If the PIHP/MCO **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP/MCO or the State must pay for those services in accordance with State policy and regulations.

## **B. PACE (Medicaid Beneficiaries)**

- PACE organization's written appeal process. The PACE organization must have a formal written appeals process, with specified timeframes for response to address noncoverage or nonpayment of a service.
- Notification of participants. Upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies a request for services or payment, the PACE organization must give a participant written information on the appeals process.
- Minimum requirements. At a minimum, the PACE organization's appeal process must include written procedures for the following:
  - Timely preparation and processing of a written denial of coverage or payment as expeditiously as the participant's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request for reassessment.
  - The interdisciplinary team may extend the 72-hour timeframe for notifying the participant or designated representative of its decision to

approve or deny the request by no more than 5 additional days for either of the following reasons:

- The participant or designated representative requests an extension.
- The team documents its need for additional information and how the delay is in the interest of the participant.
- How a participant files an appeal.
- Documentation of a participant's appeal.
- Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant's appeal.
- Responses to, and resolution of, appeals as expeditiously as the participant's health condition requires, but no later than 30 calendar days after the organization receives an appeal.
- Maintenance of confidentiality of appeals.
- Notification. A PACE organization must give all parties involved in the appeal the following:
  - Appropriate written notification.
  - A reasonable opportunity to present evidence related to the dispute, in person, as well as in writing.
- Services furnished during appeals process. During the appeals process, the PACE organization must meet the following requirements.
  - For a Medicaid participant, continue to furnish the disputed services until issuance of the final determination if the following conditions are met:
    - The PACE organization is proposing to terminate or reduce services currently being furnished to the participant.
    - The participant request continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.
  - Continue to furnish to the participant all other required services, as specified in subpart F of this part.
- Expedited appeals process.
  - A PACE organization must have an expedited

appeals process for situations in which the participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute.

- Except as provided in paragraph (f)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.
- The PACE organization may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:
  - The participant requests an extension.
  - The organization justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.
- Determination in favor of participant. A PACE organization must furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant on appeal.
- Determination adverse to the participant. For a determination that is wholly or partially adverse to the participant, at the same time the decision is made, the PACE organization must notify the following:
  - CMS
  - The State-administering agency.
  - The participant.
- Analyzing appeals information. A PACE organization must maintain, aggregate, and analyze information on appeal proceedings and use the information in the organization's internal quality assessment and performance improvement program.

## 610 Local “Grievance” (Medicaid Managed Care & PACE)

### A. Medicaid Managed Care Beneficiaries

1. Federal regulations provide Medicaid beneficiaries with the right to a local grievance process for issues that are not “**actions**”.
2. Managed Care beneficiary grievances (not actions):
  - Shall be filed with the PIHP/MCO organizational unit approved and administratively responsible for facilitating resolution of the grievance.
  - May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
  - **Do not** have access to the State fair hearing process **unless**, the PIHP/MCO fails to respond to the grievance **within 60 calendar days**. This constitutes an “action”, and can be appeals for fair hearing to the DCH State Office of Administrative Hearings and Rules for the Department of Community Health.
3. For each grievance filed by a beneficiary, the PIHP/MCO is required to:
  - Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
  - Acknowledge receipt of the grievance;
  - Log the grievance for reporting to the PIHP/MCO Quality Improvement Program.
  - Ensure that the individual(s) who are making the decision on the grievance were not involved in the previous level review or decision-making.
  - Ensure that the individual(s) who make the decisions on the grievance are health care professions with appropriate clinical expertise in treating the beneficiary’s condition or disease if the grievance:
    - Involves clinical issues, or
    - Involves the denial of an expedited resolution of an appeal (of an action).

- Submit the written grievance to appropriate staff including a PIHP/MCO administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP/MCO received the grievance/complaint. The content of the Notice of disposition must include:
  - The results of the grievance process;
  - The date the grievance process was concluded;
  - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance; and
  - How to access the fair hearing process.

## **B. PACE Beneficiaries**

For the purpose of this part, a grievance is a complaint, either written or oral, expressing dissatisfaction with service, delivery or the quality of care furnished.

- Process to resolve grievances. A PACE organization must have a formal written process to evaluate and resolve medical and nonmedical grievances by participants, their family members, or representatives.
- Notification to participants. Upon enrollment, and at least annually thereafter, the PACE organization must give a participant written information on the grievance process.
- Minimum requirements. At a minimum, the PACE organization's grievance process must include written procedures for the following:
  - How a participant files a grievance.
  - Documentation of a participant's grievance.
  - Response to, and resolution of, grievance in a timely manner.
  - Maintenance of confidentiality of a participant's grievance.
- Continuing care during grievance process. The PACE organization must continue to furnish all required services to the participant during the grievance process.
- Explaining the grievance process. The PACE organization must discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance.

## **620 Women, Infants, and Children (WIC) Participant Local Hearings**

The Department provides a hearing process through which any individual may appeal a Department or local agency action which results in a claim against the individual for repayment of the cash value of improperly issued benefits or results in the individual's denial of participation or disqualification from the program.

The Department provides a hearing at the local level and permits an individual to appeal a local agency decision to the State Office of Administrative Hearings and Rules for the Department of Community Health.

## **700 Pre-hearing Conferences**

### **All Programs**

The presiding ALJ, upon a request of any party, or on his or her own motion, may order a pre-hearing conference for the purpose of facilitating the dispositions of the matter.

**Lead Abatement; Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfer; WIC Vendor; WIC Participant, Adult Benefit Waiver Beneficiaries; Emergency Medical Personnel; Emergency Medical Systems;**

The ALJ's will **not** routinely conduct pre-hearing conferences.

### **Medicaid Provider**

A pre-hearing conference with the ALJ is routinely scheduled for all provider hearings, **except** appeals of emergency suspensions and/or terminations of a provider's participation in the Medicaid program.

### **Certificate of Need**

The Certificate of Need Rules at 1996 AACS, R 325.9503(5) provide that the first day of the scheduled hearing shall be used for pre-hearings.

## 800 Subpoenas

**Emergency Medical Personnel; Health Systems; Lead Abatement; Medicaid Beneficiaries; Medicaid Provider; Certificate of Need; WIC Vendor; WIC Participant; Adult Benefit Waiver Beneficiaries**

A subpoena may be requested when the Appellant/AHR or Department/DCH Contract Agency requires:

- A person outside the Department to come to a hearing to testify; or
- A document from outside the Department to be offered as evidence in a hearing, only if not available voluntarily.

A subpoena may be requested by sending a written request to the State Office of Administrative Hearings and Rules for the Department of Community Health. This request must include:

- The case name
- The docket number
- The date and time the hearing is scheduled
- The name and address of the person whose testimony is required
- What document is to be subpoenaed
- Why the person's presence and/or the document is needed at the hearing
- How the person's testimony or the document relates to the hearing issue

The requestor is responsible for serving the subpoena.

Allow adequate time to mail or hand-deliver the subpoena.

**Department staff is expected to participate in hearings without a subpoena when their testimony is required.**

If the Appellant/AHR or DCH/DCH Contract Agency staff responsible for presenting the hearing cannot arrange for the participation of a Department staff member, a memo may be sent to the State Office of Administrative Hearings and Rules for the Department of Community Health giving:

- The name and location of the employee;
- Why the employee's participation is needed, and
- How the employee's testimony relates to the hearing issue.

The State Office of Administrative Hearings and Rules for the Department of Community Health will decide whether to require the employee's participation.

## **810 Motions**

### **All Programs (Including Emergency Medical Professional)**

A party preparing to file motions is required to contact other parties involved in the case to attempt to resolve the matter prior to making a motion. Stipulations should be filed with the State Office of Administrative Hearings and Rules for the Department of Community Health whenever possible.

As far as practicable, Michigan Court Rule (MCR) 2.119 applies to motion practice before the State Office of Administrative Hearings and Rules for the Department of Community Health. No filing fees are required.

The State Office of Administrative Hearings and Rules for the Department of Community Health does not set aside a particular date or time to hear a motion. The State Office of Administrative Hearings and Rules for the Department of Community Health's scheduling clerk must be contacted prior to filing and serving the motion to obtain a hearing date, if one is required. The party making the motion must file and serve appropriate notice of the **hearing on the motion.**

Dispositive motions will be heard the first day of the scheduled hearing unless the ALJ agrees to hear the motion on an earlier date.

**Exception:** The Certificate of Need rules require that all pre-hearing motions be heard on the first day of the scheduled hearing.

**Health Systems hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code**

1981 AACS, R 325.21919 governs motion practice.

**Emergency Medical Personnel; Emergency Medical Services.**

2004 AACS, R 325.22360 governs motion practice.

## **820 The Hearing**

### **Medicaid Managed Care Beneficiaries Fair Hearings Process**

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- Medicaid beneficiary has the right to request a fair hearing when the PIHP/MCO or its contractor takes an “action”, or a grievance request is not acted upon within in **60 calendar days**. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See Section 300 for Notice information)
- The agency may not limit or interfere with the beneficiary’s freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP/MCO must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary’s services were reduced, terminated or suspended without advance notice, the PIHP/MCO must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP/MCO, the beneficiary and his or her representative, or the representative of a deceased beneficiary’s estate.
- Expedited hearings are available.

## **Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfer; WIC Participant, Adult Benefit Waiver Beneficiaries**

The DCH/DCH Contract Agency and Appellant will each present their position to the ALJ, who will determine whether the actions taken are correct according to fact, law, policy and procedure.

Following any opening statements, the ALJ will direct the DCH/DCH Contract Agency case presenter to explain the position of DCH/DCH Contract Agency. The hearing summary, or highlights of it, may be read into the record at this time. The hearing summary may be used as a guide in presenting the evidence, including the following in planning the case presentation:

- An explanation of the action(s) taken including all programs involved.
- The facts that led to the action.
- A summary of the policy or laws relied upon to take the action.
- Any clarifications by DCH/DCH Contract Agency staff of the policy or laws relied upon in taking the action.

Both the DCH/DCH Contract Agency and the Appellant/AHR must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross examine adverse witnesses, and cross-examine the author of a document offered in evidence. Both parties have a right to present arguments without undue interference.

The Administrative Law Judge (ALJ) must ensure that the record is complete, and may do any of the following:

- Take an active role in questioning of witnesses and parties.
- Assist either side to be sure all the necessary information is presented on the record.
- Order the hearing record to be left open to allow for the submission of evidence.
- Refuse to accept evidence that the ALJ believes is:
  - Unduly repetitious
  - Immaterial
  - Irrelevant
  - Incompetent
- Order a medical assessment to be added to the record at agency expense.

Either party may:

- State on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement; and
- Object to evidence the party believes should not be part of the hearing record.

When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and why it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides in the case being heard.

## **900 ALJ Decisions**

### **ALL Programs**

- Decisions and Orders must be based exclusively on evidence introduced at the hearing.
  - The record must consist only of:
    - The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
    - All papers and requests filed in the proceeding; and
    - The order of the Administrative Law Judge.
- The decision must be in writing and must include:
  - Statement of facts;
  - The regulation, policy, statute, contract, case law supporting the decision; (Conclusions of Law)
  - The reasons for the decision; and
  - Identify supporting evidence.

## **910 Proposals for Decision**

### **Medicaid Provider; Emergency Medical Services; Emergency Medical Personnel.**

The Administrative Law Judge will mail the proposal for decision to the parties, and each party shall have ten calendar days from the date of mailing of the proposed decision to file exceptions to the Department.

### **Certificate of Need**

The ALJ shall serve the proposal for decision upon the parties by first-class or certified mail or by personal service. Each party shall have 20 days from the date of service of the proposal for decision to file exceptions or present written arguments.

Exceptions and written arguments shall be served on all parties, who shall have ten (10) days to file their replies to the exceptions and serve the replies on the parties.

Following review of the record or the proposal for decision, exceptions, and replies, if any, the Director of the Department of Community Health shall issue an order stating the findings of fact, conclusions of law, and determination of the appeal. The Department shall serve copies of the order on all parties.

### **Health Systems hearings required by Sections 20165, 20166, 20168, 21799b(2), and 21799c of the Public Health Code**

After the conclusion of a hearing, the ALJ shall deliver, to the Director of the Department of Community Health, the official case file and the ALJ's proposal for decision. The ALJ shall serve the proposal for decision upon the parties by first-class or certified mail or by personal service. Each party shall have ten (10) days from the date of service of the proposal for decision to file exceptions or present written arguments.

Following review of the record or the proposal for decision and exceptions thereto, and replies, if any, the Director shall issue an order stating the findings of fact, conclusions of law, and determination of the appeal. The Department shall serve copies of the order on all parties.

If no exceptions are filed, the proposal for decision shall become the file order of the Department unless the director issues her order within 90 days from the date of services of the proposal for decision.

## **Nursing Home Complaints under MCL 21799(10)**

After the conclusion of a hearing, the ALJ shall deliver, to the Director of the State Office of Administrative Hearings and Rules for the Department of Community Health the official case file and the ALJ's proposal for decision. The ALJ shall serve the proposal for decision upon the parties by first-class or certified mail or by personal service. Each party shall have 10 days from the date of service of the proposal for decision to file exceptions or present written arguments.

Following review of the record or the proposal for decision and exceptions thereto, and replies, if any, the Manager of the State Office of Administrative Hearings and Rules for the Department of Community Health's hearings unit shall issue an order stating the findings of fact, conclusions of law, and determination of the appeal. The Department shall serve copies of the order on all parties.

## **920 Final Decision and Order**

### **Health Systems hearings required by Section 21774 of the Public Health Code.**

The ALJ's decision and order is the final determination of the Department.

### **Medicaid Beneficiaries; Lead Abatement; Mental Health Financial; Mental Health Transfers; WIC Participant; Adult Benefit Waiver Beneficiaries.**

The ALJ's decision and order is the final determination of the Department.

If the DCH fair hearing ALJ reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the PIHP/MCO or the State must pay for those services in accordance with State policy and regulations.

### **Medicaid Provider hearings required under MCL 400.111f**

The ALJ's decision and order is the final determination of the Department.

### **WIC Vendor**

The Final Order constitutes the Department's final decision on the appeal. A copy of the Final Order shall be sent by certified mail or served personally upon the vendor. If the adverse action under review has not already taken effect, the Final Order becomes effective on the date of receipt of the Final Order.

## **1000 Computation of Time**

If any filing deadline falls on a Saturday, Sunday or State holiday, the filing deadline shall be extended to the next business day.

## **1010 Certification of Compliance with the Judge's Order**

### **Medicaid Beneficiaries; Adult Benefit Waiver Beneficiaries**

The State Office of Administrative Hearings and Rules for the Department of Community Health will send the decision and order to the Appellant/AHR and Hearings Coordinator. If the decision and order requires implementation by DCH or a DCH Contract Agency, a DCH-0107, Order Certification form, (Exhibit III), will be sent by the State Office of Administrative Hearings and Rules for the Department of Community Health with the decision and order to the Hearings Coordinator. The DCH-0107 confirms the status of the decision and order's implementation; i.e., when the decision and order has or will be acted upon. It must be returned to the State Office of Administrative Hearings and Rules for the Department of Community Health within ten (10) calendar days of the decision and order mailing date.

Complete and return the DCH-0107 (Exhibit III) within ten (10) calendar days of the mailing date on the hearing decision. Send it to the State Office of Administrative Hearings and Rules for the Department of Community Health to certify the status of implementation. Do this even when the implementation is not yet complete.

If implementation of the decision was incomplete when the yellow copy was sent to the State Office of Administrative Hearings and Rules for the Department of Community Health, fill out and mail the pink copy of the DCH-0107 when you complete implementation. This certifies the completion of implementation.

## **1020 Rehearing/Reconsideration**

### **Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfers; WIC Participants**

DCH, a DCH Contract Agency, or the Appellant/AHR may file a written request for a rehearing/reconsideration. The State Office of Administrative Hearings and Rules for the Department of Community Health will grant a rehearing/reconsideration request if it meets specific criteria.

For Medicaid beneficiaries, if it is not likely or possible to meet the mandatory 90-day time frame, the State Office of Administrative Hearings and Rules for the Department of Community Health will ask the Appellant to waive the timeliness requirement in writing to allow the Appellant a rehearing/reconsideration.

An Appellant's request for a rehearing/reconsideration must be sent directly to the State Office of Administrative Hearings and Rules for the Department of Community Health.

The State Office of Administrative Hearings and Rules for the Department of Community Health will grant a rehearing/reconsideration when it is believed that one of the following has occurred:

- There is newly discovered evidence or evidence that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision;
- Typographical errors, mathematical errors, or other obvious error in the hearing decision that affect the substantial rights of the Appellant;
- Failure of the ALJ to address other relevant issues in the hearing decision.
- The original hearing record is inadequate for purposes of judicial review.

DCH/DCH Contract Agency staff or the Appellant/AHR may request a rehearing/reconsideration when it is believed that one of the above situations has occurred. The request shall expressly set forth the reasons for the request.

For Medicaid beneficiary cases, rehearing or reconsideration requests must be received by the State Office of Administrative Hearings and Rules for the Department of Community Health within 30 days of mailing of the Hearing decision and order. For all other cases, request must be made within 60 days from the date of mailing of the Hearing decision and order.

The State Office of Administrative Hearings and Rules for the Department of Community Health will either grant or deny a rehearing/reconsideration and send a written notice of the decision.

If a reconsideration is granted, the decision may be modified without further proceedings. If a rehearing is granted, or if there is a need for further testimony for purposes of reconsideration, the hearing shall be noticed and conducted in the same manner as an original hearing.

### **Medicaid Providers, Certificate of Need, Emergency Medical Professional, Emergency Medical Services.**

The Department of Community Health may order a rehearing on its own motion or on request of a party.

Where for justifiable reasons the record of testimony made at the hearing is found by the agency to be inadequate for purposes of judicial review, the agency on its own motion or on the request of a party shall order a rehearing.

A request for a rehearing shall be filed within 60 days of mailing of the final decision and order. A rehearing shall be noticed and conducted in the same manner as an original hearing. The evidence received at the rehearing shall be included in the record for agency reconsideration and for judicial review. A decision or order may be amended or vacated after the rehearing.

### **1100 List of Exhibits**

- Exhibit I Request for Administrative Hearing form (DCH-0092)
- Exhibit II Hearing Summary form (DCH-0367)
- Exhibit III Order Certification form (DCH-0107)
- Exhibit IV Hearing Request Withdrawal form (DCH-0093)
- Exhibit V Forms Requisition form (DCH-0646)

### **1120 How to Order Forms**

To order Exhibit I – IV listed above, please complete a Forms Requisition (form DCH-0646) (also see Exhibit V) and mail it to:

SOAHR/DCH Forms Distribution  
PO Box 30763  
Lansing, MI 48909  
FAX: 517/334-9505