

Applications and the Appeals Process

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I. Legal Basis and Background

Established by Title XIX of the Social Security Act of 1965, 42 U.S.C. §1396 “et seq.”, Medicaid is a cooperative federal-state program under which states receive federal funding to provide health care to low-income individuals. State participation in the Medicaid program is voluntary, but if a State elects to participate it *must* comply with the requirements of Title XIX and applicable regulations. Alexander v. Choate, 469 U.S. 287, 289 n. 1(1985). It is implemented by Title 42 of the Code of Federal Regulations.

If a State elects to participate in the Medicaid program, it must submit to the Secretary of Health and Human Services a state plan describing the scope of its medical assistance program, which will be administered by the State itself. 42 U.S.C. §1396a(b). Michigan is authorized to participate in the Medicaid program pursuant to §105-112e of the Michigan Social Welfare Act, M.C.L.A. §400.105-400.112e.

The Michigan Department of Human Services (hereafter DHS) administers Medicaid in Michigan. There is at least one local DHS office in each county, and more populous counties have several offices. DHS offices are open Monday through Friday during regular business hours. Their telephone numbers are listed in the phone book. For those with internet access, DHS lists the addresses, phone numbers, fax numbers, and names of the local office managers at its website, www.michigan.gov/dhs.

Generally, an individual (or someone acting on his or her behalf)¹ must fill in a Medicaid application, submit it to the local office, and have it processed and approved. If the application is approved, nothing more need be done. If it is denied, however, the applicant will not receive any assistance until a hearing is requested, and the applicant prevails either at the administrative level or on further appeal.

Understand that the consequences of a denial are severe. First, since Medicaid eligibility is based on being “impoverished”, the applicant probably cannot pay for any future health care. Second, the applicant probably cannot pay for any care provided since the Medicaid application was submitted. Third, if a nursing home is involved, it will be unable to discharge the applicant until and unless it finds a new facility to take him or her (an obviously difficult matter). Fourth, the applicant is not going to have the funds to pay for the help of a lawyer unless a family member, or a trustee is willing to pay for these services.

II. The Medicaid Application: Basics

1. As mentioned, an application containing information regarding personal matters, income, and assets of the applicant and his/her spouse must be submitted to DHS.

¹ Except for those who are so poor that they already have been placed on SSI or ADC. Individuals in these circumstances are automatically Medicaid eligible and do not need to complete an application.

Most Medicaid long term care assistance is provided in nursing homes, with some additional assistance now provided under the “Community Waiver” program.

2. Applicants in a nursing home use the FIA 4574 Medicaid application; applicants for community waiver use the FIA 1171 Medicaid application. See the appendix for samples of both applications. The information required for LTC, whether in a nursing home or under Community Waiver, remains fairly similar, although the FIA 1171 application seeks somewhat more information regarding household expenses. **(Please note that the forms and manuals have not changed the name of the agency as of yet).**
3. An original of the Medicaid LTC application must be completed for all applicants who are not SSI beneficiaries.
 - A. The applicant (or his or her representative) must begin with a blank FIA-4574 application. If the applicant is married, a blank FIA-4574B Asset Declaration also will be needed (if not already submitted).
 - B. These forms may be picked up in person at any local DHS office or the applicant can call the local DHS office and have the forms mailed out, if time allows. Many nursing homes also have a supply of these forms, which they will make available to residents. For those who seek multiple copies of the applications and/or asset declaration forms, the state DHS office may be called at 517/373-0707 and bulk copies will be mailed.
 - C. DHS will not allow an applicant to photocopy a blank application, and then complete and sign the photocopy. This obviously is pure form over substance, but it is DHS’ policy. Those who submitted completed applications based on photocopies have had their applications rejected. This may mean an absolute loss of benefits if more than three months have passed before a new application is submitted. **Keep in mind that we should not look for logic when dealing with some of DHS’ policies, and we should advise our clients of this as well.**
4. Medicaid for Married Applicants. An original “Asset Declaration” [also known as “spousal snapshot”], **Form FIA - 4574B**, also must be completed for a married applicant whose spouse is not in need of long-term care [the “community spouse” if the applicant is in a nursing home, the “non-waiver spouse” for the community waiver program]. This Asset Declaration form is used to show the value of the assets owned by either or both spouses to determine the couple’s total countable assets as of the first day of the first continuous period of care that began on or after September 30, 1989. PEM 402, page 6 of 12.
 - A. For “Community Waiver” applicants, this date is the period of at least 30 consecutive days where the applicant has been or is expected to be approved for the waiver as defined in PEM 402.

- B. For nursing home applicants, this date is the date of the current hospitalization or nursing home admission, providing there was no prior hospitalization and no prior nursing home stay of 30 days or more. **[Be sure to confirm these two points!!!]**
- i. If the applicant came from the hospital, then local office practice varies. Some offices still use the nursing home admission date; others, probably correctly, use the earlier hospitalization date. You need to know which date the DHS office to which you are applying uses. PEM 402, page 2 of 12 defines it as: “a period of at least 30 continuous days where the institutionalized spouse/applicant has been or is expected to be: in a hospital, and/or a LTC facility.”
 - ii. If the applicant had a prior nursing home stay of more than thirty days, then it is this earlier stay that is used as an “onset date,” and for which you will need to be able to show what assets the couple owned at that time, and what their values were at that time.
5. Assistance in completion of the form.
- A. Applicants residing in nursing homes may complete the form on their own, or may get help in completing the form from the local DHS office worker, from their nursing home staff, from volunteer workers, or from their attorneys. Attorney assistance in completing the application is most likely necessary if the applicant has made significant gifts, has a trust or annuity, has complicated financial dealings or has no family or friends willing to track down and submit documentation.
 - B. Applicants for Community Waiver are to get assistance in completing the application, and in providing verifications, from the contract agency administering the waiver program (PEM 106, Page 1).
6. Both applications seek extensive financial information, and people often need to get bank, insurance or other documents, which may take days or, in some cases, weeks. As noted below, **MA benefits begin on the first day of the month in which the application is filed, so it may be important to file an application before the end of the month.** In these circumstances, you should have the client complete what he or she can, file the application with the local office², and then bring in the additional information.
7. **Signatures.** The application must be signed by the client or by the client's spouse, parent, legal guardian or by someone with sufficient knowledge of the

² You can file the application with any Medicaid office, but the local one generally will be closest and most convenient. If you happen to have application with you, and are driving through a neighboring county on the day it needs to be filed, feel free to drop it off in the other county. However, they'll just ship it down to the local office, and it may get lost in transit.

client to complete the requested information. If someone other than the client signs the form, he or she becomes the client's "authorized representative." Anyone can serve in this role, providing he or she is at least 18 and has knowledge of the applicant's circumstances.

8. **Filing.** The completed application may be filed with any local DHS office in the state, and may be filed either in person or by mail. If it is not near the end of the month, submission by (certified) mail or private delivery service such as UPS or FedEx will avoid the need for an office visit.
9. **Initial benefits and retroactive benefits.** Medicaid benefits begin the first day of the month in which the application is received, irrespective of when within the month the application actually is filed. A person also can ask for retroactive Medicaid benefits for the three months prior to the month of filing the application, providing he or she was income and asset eligible during the period in question. While it usually takes **at least** 45 days for DHS to process an application, the nursing home applicant need not pay privately during this period, other than to pay his or her "patient pay amount." A "Community Waiver" applicant also should not be paying privately, although practice purportedly varies on this point

III. DHS and Application Processing

1. **Intake.** Once an application (and an Asset Declaration form where applicable) is completed and presented to DHS (for either a "community waiver" applicant or nursing home resident), the local office procedure should be the same. If the application contains at least "minimum information" (name, birthdate, address and signature), it is "registered" on the DHS computer system. DHS staff review the application to determine if it is complete enough, and if there is sufficient verification of its contents, to make an eligibility determination.
2. **Verification.** Most information on the application must be proved, or "verified." Under DHS policy, "verification" is proof from a second source that the information on the application is accurate. The basic rules regarding verification are found in the DHS Program Eligibility Manual (PEM) in Item 400 or in the DHS Program Administration Manual (PAM) in Item 130. **Most eligibility disputes are based upon verification issues.** See attached exhibit regarding problems with verification, and suggested solutions.

There are very tight time limits on verification. If information cannot be provided in the designated time, there is an absolute right to one extension of at least 10 calendar days, and most workers will provide additional time or additional extensions if necessary. However, the extension **MUST BE TIMELY REQUESTED**. If no extension is requested, and if the information on the checklist is not **received** in 10 calendar days from request, DHS will deny the application. While the person can immediately re-apply, he or she may lose coverage for earlier months.

Note - If the application is for a “Community Waiver” applicant, the local DHS office will send the verification checklist to the Waiver Agent as well as the applicant.

3. **Time Limits.** Under the "Standard of Reasonable Promptness" 42 U.S.C. §1396A(8), the local DHS office has 45 days from receiving the application to process and either grant or deny Medicaid benefits (except for persons under 65 seeking disability benefits, in which case DHS has 60 days).
4. **DHS Staff contacts.** For nursing home applicants, if processing the application seems to be taking an inordinate amount of time, the client (or representative or attorney) has the right to speak to the worker's immediate supervisor, and on up the management chain, until a suitable resolution is obtained.

If a situation seems particularly unjustified, complaints may be made to the local DHS office director, the regional DHS zone manager, or to the Office of Inquiry and Concerns, 235 S. Grand Ave., P.O. Box 30037, Lansing, MI 48909, (517) 373-0707.

For “community waiver” applicants, if processing the application seems to be taking an inordinate amount of time, the waiver agency representative should be contacted. If the DHS worker is known, she or he can be contacted as well.

Please note if the application is for community Medicaid, many CMH agencies have good relationships with the local DHS office and can assist as well.

5. **Withdrawal.** An application can be withdrawn at any time before the local DHS office decides a case. If you are advising an applicant who has already filed his or her application, and you believe he or she incorrectly completed it, have the application withdrawn.
6. **Notice of Eligibility.** The initial determination of Medicaid eligibility, whether favorable or not, is sent out on **Form FIA-1150**.
 - A. If benefits are granted, they begin as of the first day of the month in which the application was received. Retroactive benefits may be granted for up to three prior months, upon the submission of a “Retroactive Medicaid Application” [FIA-3243].
 - B. If benefits are denied, the notice will broadly state the reason for denial. The notice includes language explaining the applicant's right to appeal. A request for hearing **must** be filed within 90 days.

The worker's name and phone number will be listed on the notice. Call him or her for clarification of the basis for denial³

7. **Mandatory reporting and re-determinations.** Once Medicaid benefits have been granted, the recipient must continue to be financially and personally eligible. Medicaid recipients therefore are obligated to immediately report to the local office any changes in their financial and personal circumstances, as stated on the Medicaid application. Further, recipients must prove their continuing eligibility each year.

The "Redetermination" process occurs annually. For nursing home residents, the Medicaid recipient (or his or her authorized representative) is sent a new FIA-4574 application form, a short list of items to be verified, and a stamped and addressed return envelope to the local DHS office. The client must be given at least 10 days to complete and send back the information. The 10-day period can be extended upon request. For "Community Waiver" recipients, a new FIA-1171 is required, but this should be sent to the waiver agent, who in turn would have it completed by the recipient or authorized representative.

If the redetermination form is not returned timely, **DHS can deny continuing benefits.** It will do so by sending out a "case action" notice as described below.

One issue which causes concern and confusion with the annual redetermination process is that both the FIA-4574 and the FIA 1171 applications require asset information about both the current Medicaid recipient **and** the spouse. The spouse's assets are not relevant to DHS, once eligibility is established. We have always relied upon CMS letters in support of this position or interpretation. The June 29, 1999 letter from Robert Reed, Chief, Medicaid Branch, Division of Medicaid and State Operations, Dept of Health and Human Services, to Roderick Gere, states "Under the spousal impoverishment provisions, once eligibility is determined, the resources of the community spouse are no longer considered available to the institutionalized spouse. Thus, after the eligibility determination any resources belonging to the community spouse are solely the property of that spouse. That spouse can do whatever he or she wants to with them..." (Citing 42 U.S.C. §1396r-5(c)(4): "During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this subchapter, no resources of the community spouse shall be deemed available to the institutionalized spouse.") An April 6, 2000 letter from Ronald Preston, Associate Regional Administrator of the Department of H&HS, to Brian Barriera, stated essentially the same thing.

³ If you are familiar with Medicaid policy, and if you believe the worker misapplied it, talk to him or her about it. Many practitioners are successful in getting the denial overturned at this level, but of course it will depend on the DHS office and worker you are dealing with.

That all sounds encouraging, except that the term “resources” used above may not include an exempt asset such as the house. 42 U.S.C. §1382b(a)(1) specifically excludes the home from the determination of “resources.” Keep in mind that there is a 1999 CT Superior Court case that held such a transfer caused a penalty period. (Conn. Super. Ct., No. CV 980063936, 1999 WL 1120130, Nov. 23, 1999), and of greater concern are recent CMS letters (dated 9/13/04) to Michael Millonig and (dated 5/28/04) to Robert Richardson that reverse CMS’ position on this. They now state that a state may interpret the statutory language in reasonable ways and post eligibility transfers by the community spouse may be subject to each state’s interpretation of the Federal law.

IV. Pursuing a Medicaid Denial - Background:

DHS takes "case actions" whenever it receives information and makes a decision about a person's Medicaid eligibility, whether it is triggered by the initial eligibility determination, the annual redetermination process, or reports from sources such as IRS tape - matches or Secretary of State or the Register of Deeds. Case actions may be positive (a determination of increased benefits or spousal allowance) or negative (a denial, reduction or termination of benefits).

1. Case actions are entered on the DHS’ Computer Information System (CIS), and a written notice is sent to the client and/or his or her authorized representative. The notice must:
 - A. Describe the action, the reason for it, the manual item forming the legal basis for the action, and the person's right to a hearing.
 - B. If the notice involves reducing or terminating current Medicaid benefits, the Medicaid recipient generally⁴ has a right to continue to receive his or her present benefits until a hearing is held and a decision rendered, if the client asks for a hearing within 10 days of the notice.

(Unfortunately, an initial applicant who has been denied Medicaid has no right to benefits until the denial is successfully appealed, or a new application is submitted and proven. This may well take months or even years, presenting obvious problems for a person needing support.)

V. Pursuing a Denial: Basic Procedures

1. **Bases for hearings.** A client can request a hearing before an administrative law judge for: the denial, reduction or termination of Medicaid benefits (including, for community clients, matters involving medical transportation and payment for and

⁴ This right does not apply if the reduction or termination is based solely on a federal or state law requiring an automatic change adversely affecting some or all recipients. For example, the federal government repeals the Medicaid program.

amounts of home help services); delay in processing the application or issuing benefits; and for community spouse income and asset allowances and allowances⁵.

3. **Dual hearing authority.** While Medicaid is primarily administered by DHS, policy and medical treatment issues are administered by the Department of Community Health (DCH). Most Medicaid denial issues have to do with financial eligibility and personal status matters, and hearings on these issues are held by the Office of Administrative Hearings of DHS. However, occasional medical issues arise, primarily in “community waiver” cases, such as whether a particular type of home health service is necessary or appropriate for an applicant. Hearings on these issues are held by the Office of Administrative Tribunal of DCH. The time frames, standards and rules remain the same. Both Sections of Hearing Officers have very recently been combined substantive issues for hearings raised under DRA (see Attachment 1).
 - A. Premiums and Costing Sharing (pages 4 – 9).
 - B. Benefit Package and Case Management (pages 11 – 17).
 - C. Citizenship Documentation (pages 17 – 20).
 - D. Hardship Waiver (see Sandy’s materials).
4. **The hearing request.** Applicants and/or recipients have **90** days to get their Request for Hearing” into any office of DHS once they have received notice of an action affecting their eligibility. Both the DHS forms for case action and Medicaid eligibility explain the 90-day limit and the procedure for requesting a hearing.
5. The hearing request must be written, and signed by the client or by one of the following representatives:
 - a representative with written authorization signed by the client⁶; or
 - a guardian or conservator; or
 - the legal parent of a minor child; or
 - the attorney at law for the client; or for MA only, the client's spouse, or the deceased client's widow or widower, but only when no one else has authority to represent the client's interest in the hearing process.

NOTE -- An "authorized representative" does NOT have the

⁵. Providing an application has been filed and denied. If a Asset Allowance form is submitted prior to application, and the Asset Allowance is denied, the denial can be pursued when the application ultimately is submitted.

⁶. A “Durable Power of Attorney” that includes specific authority to request a hearing on the principal’s behalf usually works.

authority to request a hearing, or to designate someone else as having the authority to request a hearing, unless the authorized representative ALSO happens to be the spouse or guardian or conservator of the applicant, or unless the applicant previously had given the authorized representative specific written authority to request a hearing. This is a potential trap. Many and perhaps most LTC applications are submitted by the adult children or other family members of the persons needing long term care. Most of these individuals are not under a guardian or conservator, nor have they given a written statement to their family members authorizing them to request a hearing.

6. The forms that DHS uses to report a denial of Medicaid (FIA-1605 & FIA-4598) include a signature line on them, so that they can be signed and sent in as a hearing request. There also is a DHS general form for requesting a hearing. However, using these forms is not mandatory, and a simple letter to DHA, indicating the person's name, MA file number, and requesting a hearing will suffice (providing it is timely and appropriately signed).
7. Only the Office of Administrative Hearings (or Office of Administrative Tribunal) may deny a hearing request, and local DHS offices must forward all requests to it for determination.
8. Generally, failing to request a hearing within 90 days results in the permanent denial of benefits for the period in question. You client of course can always re-apply and sometimes this is a quicker way to get benefits – while fighting over another time frame.

VI. Pre-Hearing Procedures.

Upon receiving a hearing request, the local DHS office must do the following:

1. Try to resolve disagreements and misunderstandings at the lowest possible level to avoid unnecessary hearings. These efforts are to continue right up until the actual hearing.
2. Have the Assistance Payments supervisor review every hearing request to make sure it is necessary.
3. Offer a "pre-hearing conference" to try to resolve the DHS problem. At the conference, DHS must: determine why the client is disputing the action; review any documentation the client offers; decide if the dispute can be resolved without a hearing; and explain DHS' position to the client. If DHS determines it is in error, it must grant the requested benefits and ask the client to withdraw his or her hearing request. There is a DHS general form which can be used, or the client can sign a letter to the same effect.

4. DHS must complete a hearing summary for every case, using form FIA 3050. The summary must include a statement of case action, the facts and policy on which the action was based, and the documents the local office intends to introduce at the hearing.
5. A "hearings administrator" or coordinator at the local office must review the hearing request and summary.
6. The local office must (and will) allow applicants and their advocates and attorneys to review the case file. It also must (and will) allow the applicant or representative to copy anything in the file except for certain court/law enforcement records.
7. If you do not receive a hearing summary, a pre-hearing conference call may be requested.

VII. The Hearing

A. Background:

There are several sources of rules and procedures for administrative hearings, including federal (42 CFR 431.200 et seq, Subpart E - Fair Hearings for Applicants and Recipients); Michigan Administrative Code (R 400.901 et seq, Hearings Appeals and Declaratory Rulings), and DHS policy (PAM Item 600). See also Chapter 4 of the Michigan Administrative Procedures Act, MCLA 24.271.

1. Hearings are held by administrative law judges, who are required by law to be impartial. In the author's experience, they mostly are, notwithstanding that they are DHS (or DCH) employees.
2. The claimant may be represented by an attorney or anyone else, at his or her own expense. DHS may be represented by legal counsel, although this seems rarely to occur.
3. Hearing notices are mailed at least 10 days in advance, and give the time, date and place of the hearing. Adjournment requests must be made to the Office of Administrative Hearings (or Administrative Tribunal). Usually, they are liberally granted.
4. DHS initially schedules all cases as "DHS telephone hearings." These are proceedings wherein the Medicaid applicant and his/her representative go to the local DHS office, sit in a conference room with the DHS staff, and use a speaker phone to communicate with the administrative law judge in Lansing or Detroit. However, there is an absolute right to an in-person hearing, at which the Administrative law judge is present and able to

assess credibility, review the case file with both parties, and review and approve documents offered for admission.

5. The administrative hearing is supposed to be held and the decision issued AND implemented within 90 days of the request for hearing, although this time frame is often missed. The Author has successfully filed a Writ of Mandamus to compel a decision to be issued.
6. The administrative law judge's decision must be based solely upon evidence introduced at hearing, and must contain both findings of fact and conclusions of law. In most cases, the issue is whether DHS policy was appropriately applied. Occasionally, the issue may be whether DHS policy is lawful.
7. The decision is mailed to the local DHS office, the applicant, and his or her representative. If the decision is favorable, the local DHS office must implement the decision within 10 days of issuance. The decision will be retroactive to the time of application (or earlier).

B. Hearing procedure:

1. The hearing is held at the local DHS office. If an "in-person" hearing, the administrative law judge is present with a tape-recording system, so that the hearing may be transcribed if necessary. **NOTE:** Double check the tape recorder is working correctly. The Author has experienced "blank tapes" after a lengthy hearing. If a "telephone" hearing, the administrative law judge presumably has the tape recorder attached to the his or her end of the phone. Prior to going on the record, the administrative law judge may ask the attorney and AP supervisor to explain their respective positions (**and be aware that resolution is often reached at this point**). Once ready to proceed, the administrative law judge usually gives a brief explanation of the hearing process to the attendees, and then swears in the people who will testify.
2. DHS first presents its decision and the reasoning for it, along with documentary evidence and testimony. Usually the Assistance Payments supervisor will present DHS' case, using the testimony of the assistance payments worker who denied the client. The caseworker may be cross-examined. **PRACTICE NOTE** - the supervisor may not consider it necessary to have the case worker who processed the application present. If you intend to take testimony from the worker, then you need to confirm his or her presence ahead of time with the supervisor and/or hearings administrator. Put it in writing. If you don't get a satisfactory answer, contact OAH and advise them that you want the particular worker present.
3. The client (or representative) then explains his or her position, and

presents any additional information needed. Not surprisingly, the actual applicant is most often not present because of poor health and it is the spouse or child who actually offers testimony. The judges are accustomed to, and do not object (or entertain objections) to hearsay.

4. Exhibits are introduced as needed, offered to the other side for review, and marked by the administrative law judge. The majority of DHS' exhibits will have been sent out earlier attached to the Hearing Summary, although it is not unusual for DHS to add one or two additional exhibits at the hearing. They aren't supposed to. Objections to documents not previously offered by DHS or found in the case file may be made, but, based on experience, probably will not be granted.
5. Evidentiary rules are very informal. Historically, ALJs require only that the information be of the type commonly relied upon by reasonable and prudent persons. See MCL 24.235. PAM 600 states that ALJs are to follow the "same rules used in Circuit Court," but then qualifies this out of any true meaning by noting that ALJs may be more lenient than Circuit Judges. They also may actively engage in questioning witnesses and parties (PAM 600, page 28). **Be aware that they frequently do this.**
6. Most cases turn on whether the local office properly applied DHS policy as stated in the manuals. Attention both in cross examination and in presenting the client's case should focus on specific manual items (or law) and how they were applied.
7. **PRACTICE NOTE.** Although not required, you should always: review the case file prior to the date of hearing (usually at the pre-trial conference); prepare a brief and submit it at the hearing; have written questions for your witnesses so you will be certain that you've covered all your bases; and make a closing argument. Further, you can ask, and probably will be allowed, to submit a written Closing Argument/Brief. If you really want to push the limit, you can draft a "Proposed Decision."
8. The administrative law Judge's decision
 - A. The hearing decision must be based solely upon evidence introduced at hearing, and must contain both findings of fact and conclusions of law. In most cases, the issue is whether DHS policy was appropriately applied. Occasionally, the issue may be whether DHS policy is lawful or, alternately, if DHS policy is silent on the issue being considered.

The administrative law Judge **only** has the authority to issue a final decision on his or her own if the issue is whether DHS policy was appropriately applied. If the issue is whether DHS policy is lawful (or

silent), the administrative law judge may only make a recommended decision to the "Policy Hearing Authority." If the issue relates to Medicaid eligibility (as most will), and DHS policy "does not conform" to federal or state law, the ALJ issues a "recommended decision" within 20 days (although it is unlikely that there is any penalty for failing to meet this standard). The decision is forwarded to the parties as well as the "chief executive officer" of DCH-MSA, all of whom may file exceptions with the ALJ. The ultimate decision then is made by the Director of Department of Community Health.

Once the final decision is issued (almost always by the ALJ, occasionally by the Policy Hearing Authority or DCH/DHS-director), it is mailed to the local DHS office, the claimant, and his or her representative. If the decision is favorable to the claimant, the local DHS office must complete a certification form and return it to the Office of Administrative Hearings to ensure that the decision is implemented within 10 days of issuance. The decision will be retroactive to the time of application (or earlier if retro benefits were sought).

If it is unfavorable, the appeal period begins to run.

- B. Rehearings and reconsiderations -- Within 30 days of receipt of decision, either the client or DHS can request a rehearing or reconsideration⁷, in writing, from the Office of Administrative Hearings if there is newly discovered evidence or if there was inaccurate use of manual policy or law in the hearing decision. The Office of Administrative Hearings has full discretion in deciding whether to allow a rehearing. The client is not obligated to seek a rehearing before seeking an appeal of the decision.

Note -- DHS cannot get a rehearing if it has been 90 days or more from the initial request for hearing by the client, unless he or she agrees to waive his or her rights or if it was client's request for postponement that caused the delay.

VIII. Circuit Court Appeals

- A. **The appeal.** The primary rules and procedures for appeals from administrative hearings are found at MCR 7.105 and Chapter 6 of the Michigan Administrative Procedures Act, MCLA 24.301 et seq.

An appeal may be based on one or more of the following claims: that the

⁷. A "rehearing" is a full, new hearing granted when the record from the first hearing is inadequate to make a decision. A "reconsideration" is a paper review of the initial hearing when the record is adequate for a decision, but one of the sides alleges the ALJ did not address all issues.

administrative hearing decision is in violation of the constitution or statute; it exceeds the authority of the agency; it was made upon unlawful procedure resulting in material prejudice; it is unsupported by competent, material and substantial evidence of the whole record; it is arbitrary, capricious or clearly an abuse of discretion; or it is affected by other substantial and material error of law, MCLA 24.306.

B. Procedure.

1. The appeal, entitled "Petition for Review," must be drafted and filed with the Circuit Court within **30** days of receiving the administrative hearing decision. Venue is in the county in which the Medicaid recipient resides, or in Ingham County. The petition must allege one or more of the above bases as grounds for the appeal. The administrative decision being appealed must be attached.

NOTE - If Petitioner wants to seek additional evidence, or argue that the agency's procedure at the hearing was unlawful, these requests must be included in or with the Petition. See Subparagraph 6. below.

2. Service is made by mailing the Petition to both DHS and the Office of the Attorney General (hereafter AG), and filing an appropriate proof of service.
3. Upon receiving the petition, the AG's office will order the record to be prepared (requiring the tape recording of the hearing be transcribed) and forwarded to the court and to the Petitioner. This should not take more than 60 days. Note: the author usually request this in advance.

The notice will indicate the name of the Assistant Attorney General assigned to the case (at least for the moment — assignments seem to frequently change).

The AG's office may, but need not, file an answer to the Petition.

4. Once the record is filed, Petitioner has 28 days to prepare and file his or her brief with the court. If more time is needed, Petitioner may ask the AG to stipulate to a 28-day extension, or may ask the court for a 28-day extension.

Once Petitioner's brief is filed, the AG has 28 days to prepare and file a responsive brief (and also may seek a 28 day extension).

Petitioner may, but need not, file a reply brief within 14 additional days.

5. The briefs must be in the same form as required for briefs to the Court of Appeals. See MCR 7.212. **PRACTICE NOTE** -- Do not **under-estimate** how much time this takes, or how prone photocopy, printer,

computer and related equipment is to breaking under deadline.

Petitioner and the AG may request oral argument, which the court will schedule.

6. MCR 7.105 specifically allows the use of several types of "Motions" as part of the appeals process:
 - A. Petitioner may move to present additional evidence. The request must be made either in, or filed with, the Petition. It is scheduled according to usual motion practice. If granted, the time for filing briefs will be extended until the new evidence is heard and a new decision issued.
 - B. Petitioner also may move to present evidence of agency irregularity in the handling of the case. Again, this request must be made in, or with, the Petition, and is scheduled according to usual motion practice.
 - C. The court rule provides that either Petitioner or the AG may file what is in effect a "summary disposition" motion.

The AG may move to dismiss the Petition on the grounds of lack of jurisdiction, improper procedure, mootness or failure to exhaust administrative remedies. The AG also may seek to summarily affirm DHS' decision on the basis that the questions to be reviewed are so insubstantial, or so improperly or untimely raised, as to not justify the submission of briefs.

The petitioner alternately may file for peremptory reversal of the agency decision on the ground that the agency's error is so manifest as to require an immediate decision and not justify the filing of briefs.

- D. Either party or the court may move that costs be awarded for "Vexatious Proceedings" for much the same reasons as provided for sanctions under MCR 2.114(E).
7. After oral argument is heard, or if not requested, after the briefs have been submitted, the case is submitted to the judge for decision.
8. The judge's decision shall be written. It may affirm, reverse, remand **or modify** the decision, and may grant such relief as appropriate. At least in theory, a favorable decision for Petitioner may avoid the need for any further DHS administrative proceedings.

Of particular importance in any further appeals is whether the decision

entered by the circuit court constitutes a “Final Order or Judgment,” since there is only a 21 day appeals period following the entry of such an order.

The definition of “final order” is found at: MCR 7.202(6)(a);

(a) In a civil case,

- (i) the first judgment or order that disposes of all the claims and adjudicates the rights and liabilities of all the parties, including such an order entered after reversal of an earlier final judgment or order, or
- (ii) an order designated as final under MCR 2.604(B).

Be aware that this can be significant. If the court issues something entitled “Opinion,” and the opinion disposes of all issues, your 21 days has begun to run. Don’t wait for a separate “Order.”

9. Three recent victories/interesting appeals:

- A. James Schuster appealed in Oakland County Circuit Court an ALJ decision that savings bonds were available resources during the 12 month mandatory retention period. Honorable Denise Langford Morris on 11/17/04 overruled the decision as contrary to law, stating, “where the Federal secretary has made a determination of eligibility for SSI recipients, that determination is controlling on State Medicaid programs.” The decision cited Schweiker v. Gray Panthers, 453 U.S. 34 (1981).
- B. Sue Fabian appealed in Washtenaw County Circuit Court a denial of an increase in the community spousal income allowance based on “exceptional circumstances” for a reason that otherwise is barred by PEM 600. She prevailed in a 2nd Administrative Appeal, before it got to Circuit Court.
- C. Doug Chalgian prevailed in front of Marlene B. Magyar on the issue of a mobile home being treated as an exempt homestead.
- D. Any others? Freedom of Information Request of Hearing Decisions?

IX. Further Appeal to the Court of Appeals & Beyond

- A. Basic process: The primary rules and procedures for appeal to the Court of Appeals from the circuit court are found in MCR 7.200. The most significant is that appeals of DHS hearings, already reviewed at the Circuit Court level, are to the Court of Appeals by Leave only; there is no Right to Appeal. See MCR 7.203(A)1(a) & 7.203(B)2.

PRACTICE NOTE -- If you do not do appellate work in your regular practice, do NOT attempt an appeal without first reviewing the most current court rules⁸, all secondary materials available (such as the chapter on Appeals in *Michigan Basic Practice*, ICLE), and associating with someone with appellate practice. There are many procedural pitfalls.

B. Appellant's Initial Procedure: The process for Appeals by Leave is laid out at MCR 7.205 (B).

1. Five copies (one signed) of the "Application for Leave to Appeal," must be filed with a clerk of the Court of Appeals at one of its locations within **21** days of entry of the final order by the Circuit Court. The application must state the date and nature of the judgment/order appealed from and include a concise recitation of allegations of error and relief sought. If the appeal is from an interlocutory order (i.e., NOT a "final order") of the circuit court, there must further be an explanation of why the appellant would be harmed if he or she were required to wait until final judgment by the circuit court. Each application must include a supporting brief, one that complies with MCR 7.212(c).

PRACTICE NOTE --Again, do not **underestimate** how much time this takes, or how prone photocopy, printer, computer and related equipment is to breaking under deadline

2. Attached to each application must be a copy of the judgment/order appealed from; a copy of the docketing/calendar entries; a copy of the administrative decision; and, with the five completed applications, there must be one copy of the transcript of the administrative hearing that was reviewed by the circuit court.
3. A Notice of Hearing must be prepared, and scheduled for the first Tuesday that occurs 21 days after a copy of the above documents are served upon all other parties.
4. Proof of Service must be prepared and served, and
5. The appellate fee must be paid.

C. Appellee's Initial Procedure: The appellee may, but need not, respond to the Application, as provided at MCR 7.205(C). Considering what is at risk, it would seem rare for a party to choose NOT to respond. If responding, appellee may file:

⁸ Be aware that appellate rules change very frequently, and the Court of Appeals is very rigorous in its adherence to these rules.

1. Five copies of an Answer to the application (one signed)
2. Five copies of an Opposing Brief (pursuant to MCR 7.212(D))
3. Proof of service.

D. The Court of Appeals response:

1. Notwithstanding that appellant must file a Notice of Hearing at a time certain, the decision whether to grant the Application for Leave to Appeal, at least initially, is without oral argument or further input from the parties. The decision is made solely on the documents filed.
2. The Court of Appeals has very broad powers. It may grant or deny the application, enter a **final** decision, grant other relief, request additional material, or require other information. This decision, whatever it may be, is mailed to the parties.
3. If the application is denied, then Appellee probably⁹ is reduced to seeking further review in the Supreme Court, pursuant to MCR 7.300
4. Assuming the application for leave to appeal is granted, then the Court of Appeals certifies its Order granting leave to appeal, and the matter proceeds as an Appeal of Right (as covered in MCR 7.204, and later rules), but only as to those issues raised in the Application for Leave to Appeal (including its supporting brief).

E. Appeals of Right: The process is laid out at MCR 7.205. For an Application for Leave to Appeal that has been converted into an Appeal of Right, the appellant does NOT need to file a new “Claim of Appeal,” nor, apparently, pay a new fee. However:

1. Appellant has 28 days to file a “docketing statement,” pursuant to MCR 7.204(H).
2. Appellant has 56 days for file his or her new brief, said brief again complying with the provisions of MCR 7.212 (note - there is a shorter period of time for certain criminal or child custody matters). The parties may stipulate to a 28-day extension.
3. Appellee has 21 days to file a “cross appeal” if appellee has separate issues with the lower court decision with which he is dissatisfied

⁹ Unless the denial was because the request for leave to appeal was more than 21 days from issuance of a final order. There is a procedure for filing a “Late Appeal” within 12 months of issuance of a final order (MCR 7.205(F), but approval is even less likely.

(probably unlikely). There will be a \$250.00 filing fee for the cross-appeal.

4. Appellee has 35 days from receipt of appellant's brief to reply.
5. Oral argument can be requested, although the court has also been hearing certain cases without oral argument, irrespective of the parties' requests.
6. Motion Practice. As provided at MCR 7.211.
7. Decision/Opinion. Hopefully, it will be favorable. Otherwise, you are looking at an appeal to the Supreme Court, pursuant to MCR 7.300 et seq.

X. The New Level of Care Determination Screening Tool.

The entire Nursing Facility Level of Care Determination Policy (90 pages in length) can be found at: http://www.michigan.gov/documents/MSA-04-15_104506_7.pdf.

1. Why?

- A. Inconsistent practices for enrollment across all three LTC programs.
- B. Includes only those persons appropriate for Nursing Facility Level of Care (NF LOC).
- C. A beginning step to look at overall LTC system and the relationship of eligibility criteria across other programs – such as Home Help.

2. Eager Decision:

Legal settlement requiring the State of Michigan to implement specific changes to the admission and enrollment processes for Long Term Care services.

3. The Impact of Eager

- A. MDCH is required to develop and implement a process to ensure Informed Choice for all beneficiaries who meet the nursing facility level of care.
- B. This was done in an attempt to address the built in institutional bias in the Medicaid System.
- C. Further, it is consistent with 42 CFR 440.230(d): “The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”
- D. MDCH has developed a common form to acknowledge that the provider fully described all three LTC program options to the applicant at time of

application.

- E. As part of the process, MDCH must implement training on the Informed Choice Process and community options for LTC for NF providers, hospital discharge planners, MI Choice agents and PACE (Wayne County).

XI. Other Advocacy Issues to Consider and sample completed forms and sample complaints.

The Poor Michigan economy has resulted in little improvement in terms of real choices for Long Term Care Services in the community. Although progress is being made, please consider:

1. *Single Points of Entry*, where individuals needing long-term care will have a single point of contact where they can be adequately assessed and referred to the appropriate programs based on their physically and financial needs. The goal is to promote coordination and accessibility to appropriate providers and programs so that the individual's independence is maximized while receiving adequate support services. See attachments 2 - 3 regarding Single Point of Entry Pilots and Legislation.
2. *Elimination of Institutional Bias* through the promotion of (1) "money follows the person" where the individual eligible for assistance receives a voucher and can "shop" for their own provides; (2) person-centered planning, where the individual actively participates in their treatment planning and has more control over their own care; and (3) case mix reimbursement, where the amount of Medicaid benefits to a nursing home resident varies depending on the specific needs of the resident, rather than a flat rate. DRA Section: 6071, 6087 – see Attachment 1.
3. *Modifications to Home and Community-Based Waiver Services* including (1) the use of Waiver funds to be used in assisted living facilities and adult foster care home; (2) a spend down program for Waiver services, and (3) a patient pay amount for Waiver services. DRA Section 6086 – see Attachment 3.

What do we as advocates do in the meantime? ---

- ◆ Sample Cover Letter – *Attachment 4*
- ◆ Office of Civil Rights-Frequently Asked Questions with Answers – *Attachment 5*
- ◆ Fact Sheet-How to file a Discrimination Complaint with the Office for Civil Rights – *Attachment 6*
- ◆ Sample Discrimination Complaint – *Attachment 7*
- ◆ Complaint and Jury Demand – *Attachment 8*
- ◆ Assets Declaration – *Attachment 9*
- ◆ Assistance Application – *Attachment 10*
- ◆ Medicaid Application – *Attachment 11*