STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-43198 HHS
[redacted]

AMENDED DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], was present. She was represented by [redacted], [redacted] and [redacted]. [redacted], Appeals Review Officer, represented the Department of Community Health (Department). [redacted], Adult Services Worker (worker), testified as a witness for the Department. [redacted], Adult Services Supervisor, was also present for the hearing. However, at that hearing, all of the information needed to resolve this matter was not obtained. Therefore, a continued hearing was held on [redacted]. The Appellant, [redacted] and [redacted] were again in attendance, as well as [redacted] the Appellant's family member and witness.

ISSUE

Did the Department properly suspend the Appellant's Home Help Services (HHS) payments?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary who participates in the HHS program.

2. The Appellant has been diagnosed with hypertension, severe back pain, COPD, and depression. (Exhibit 1, page 12)

3. The Appellant had been receiving payment assistance for the following Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): bathing, grooming, housework, laundry, shopping, and meal preparation. (Exhibit 1, page 9)

4. In [redacted], a letter was sent to the Appellant providing notice of an annual redetermination and advising that the Appellant's chore provider needed to be present. (Testimony of Williams)

5. An annual redetermination was conducted on [redacted], to determine the Appellant's continued need for services. (Exhibit 1, page 11) The Appellant's chore provider was not present. (Testimony o[redacted])

6. In [redacted], the worker became aware that the Appellant was missing provider logs for several months in [redacted]. (Exhibit 1, page 10)

7. The worker sent a Negative Action Notice on [redacted] with an effective date of [redacted], informing the Appellant that her HHS payments were suspended because the worker had not had any contact with the Appellant's chore provider and because of the missing provider logs. (Exhibit 1, pages 4-7)

8. On [redacted], the worker spoke with the Appellant by phone and scheduled a meeting for [redacted] at the DHS office. At that time, the Appellant advised the worker that she had a new chore provider, [redacted], who had been providing services to the Appellant since [redacted]. (Exhibit 1, page 10)

9. On [redacted], the worker met with the Appellant and her new chore provider at the DHS office. At that time, the new provider filled out the required enrollment forms and indicated that his start date was [redacted]. (Exhibit 1, page 10)

10. The Appellant requested a hearing on [redacted] (Exhibit 1, page 3)

11. Hearings were conducted in this matter on [redacted]

12. On [redacted], a decision and order was issued, affirming in part and reversing in part the Department's action.

13. After the decision and order was issued, the Administrative Law Judge was advised that the Appellant had submitted additional documentation during the period that the record was left open. That additional documentation was not considered when issuing the [redacted] decision and order.

14. The Administrative Law Judge has since considered the additional documentation, and it does not affect the outcome of this case.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

The purpose of HHS is to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a health professional and may be provided by individuals or by private or public agencies.

DHS HHS staff is mandated to conduct regular reviews of HHS cases. The DHS policy related to assessment and reviews states, in pertinent part, as follows:

COMPREHENSIVE ASSESSMENT

> The Adult Services Comprehensive Assessment (FIA-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.
>
> Requirements for the comprehensive assessment include, but are not limited to:
>
> • A comprehensive assessment will be completed on all new cases.
>
> • A face-to-face contact is required with the customer in his/her place of residence.
>
> • **An interview must be conducted with the caregiver, if applicable**.
>
> • Observe a copy of the customer's social security card.
>
> • Observe a picture I.D. of the caregiver, if applicable.
>
> • **The assessment must be updated as often as necessary, but minimally at the six-month review and annual redetermination**.

> • A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency record.
>
> • Follow specialized rules of confidentiality when ILS cases have companion APS cases.
>
> *Adult Services Manual (ASM 363 9-1-08), page 2 of 26*
> (Bold emphasis added by ALJ).

REVIEWS
ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review
Requirements for the review contact must include:

> • A review of the current comprehensive assessment and service plan.
> • A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
> • Follow-up collateral contacts with significant others to assess their role in the case plan.
> • Review of client satisfaction with the delivery of planned services.

* * *

Annual Redetermination

> Procedures and case documentation for the annual review are the same as the six month review, with the following additions:
> Requirements:
>
> > • A reevaluation of the client's Medicaid eligibility, if home help services are being paid. • A new medical needs (DHS-54A) certification, if home help services are being paid.
> > **Note:** The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.

> • A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.
>
> *Adult Services Manual (ASM 363 9-1-08), page 6-7 of 24*

At the hearing, the Department acknowledged that the missing provider logs had been submitted to the worker. Therefore, the Department proceeded solely on the ground that the suspension was warranted because the worker had not had contact with the Appellant's chore provider.

There is no dispute between the parties that the chore provider was not present at the annual redetermination conducted on [redacted]. (Testimony of [redacted]; Testimony of [redacted]). The worker testified that policy requires her to meet with the Appellant's chore provider annually to verify that the chore provider is providing services to the Appellant and to get an update on the case. The worker stated that she advised the Appellant at the redetermination that her chore provider would need to contact the worker and meet with the worker at the DHS office.

The Appellant testified that the worker was over two hours late getting to her house for the redetermination. The Appellant further testified that she explained to the worker at the redetermination that her former chore provider was not present because he was working and that she had a new chore provider that was going to begin providing her services beginning in [redacted]. The Appellant stated that she also told the worker that her former chore provider would be training her new chore provider. However, at another point in the hearing, the Appellant stated that her new chore provider "took over" for her former chore provider in [redacted]

The Appellant further stated that she knew that she was suppose to come in to meet with the worker with her new chore provider. But she stated that she tried to contact the worker countless times by telephone—everyday and sometimes twice a day—between the end of [redacted], when she received the negative action notice, and [redacted], but she was unable to get through to the worker. The Appellant's representative and witness confirmed that several calls were made to the worker. But no documentation was provided at the hearing to support that any of these calls were made, even though the Appellant asserts that a log does exist.[1] Further, the Appellant's representative could not provide a time frame for when these calls were made. The Appellant further testified that she went to the office in [redacted] but the office was closed, and in [redacted] she could not walk.

The worker testified that she did not begin receiving calls from the Appellant and her representative until [redacted]. The supervisor explained that the DHS office was deployed from [redacted], but she and the worker cleared their voicemail daily, and she and the worker did not receive any voicemail messages from the Appellant during that time. The worker stated that the first time she was made

[1] The record was left open for the Appellant to provide this information. However, nothing was provided.

aware that the Appellant had a new chore provider was during their telephone conversation on [redacted]

The worker also testified that there was a discrepancy between the Appellant's new chore provider's statement of employment, which indicated that he began providing services to the Appellant on [redacted], and her former chore provider's provider logs, which indicated that he provided services through the end of [redacted]. (Exhibit 2, pages 2-4) In addition, the worker testified that there is question whether the Appellant's former chore provider actually signed the provider logs because the signature on the logs does not remotely resemble the signature on the former provider's statement of employment or his driver's license.[2] (Exhibit 2, pages 2-3; Exhibit 3) The worker indicated that these issues further warranted the suspension of the Appellant's payments pending a meeting with her former chore provider.

The Department's suspension of payments in this case was proper. The worker was required to meet with the chore provider at the time of redetermination. The fact that she was unable to do that and the subsequent discrepancies with the Appellant's former chore provider's logs support the temporary suspension of HHS payments in this case.[3]

However, the Department's retroactive suspension was not proper. Pursuant to the [redacted], Advance Negative Action Notice, the Department implemented the suspension of the Appellant's case retroactive to [redacted] The Code of Federal Regulations, Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

> **§ 431.211 Advance notice.**
> The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.
>
> **§ 431.213 Exceptions from advance notice.**
> The agency may mail a notice not later than the date of action if—
> (a) The agency has factual information confirming the death of a recipient;
> (b) The agency receives a clear written statement signed by a recipient that—
> (1) He no longer wishes services; or

[2] This Administrative Law Judge confirms that the signatures are not at all similar. However, the record was left open, and the Appellant provided a notarized letter from her former provider, confirming that he did, in fact, sign the provider logs but that his signature was different from his statement of employment and license because he had a brace on his right wrist at the time he signed them. (Exhibit 4)

[3] This Administrative Law Judge notes that payments to the Appellant's new chore provider began on [redacted], which, pursuant to the provider logs, was the first day that the former provider no longer provided services to the Appellant.

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);
(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the recipient's physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

§ 431.214 Notice in cases of probable fraud.
The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
(b) The facts have been verified, if possible, through secondary sources.

The [redacted] Advance Negative Action Notice issued by the Department clearly failed to provide the Appellant with the required advance notice of at least 10 days that her HHS payments would be suspended, as the effective date of the reduction was [redacted] (Exhibit 1, pages 4-7) None of the exceptions to the advance notice requirement were present in this case. Therefore, the Department should not have suspended the Appellant's HHS case any earlier than ten days from the date of the [redacted] Advance Negative Action Notice.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly suspended the Appellant's HHS payments. However, its retroactive suspension was improper.

IT IS THEREFORE ORDERED that:

The Department's decision is PARTIALLY AFFIRMED and PARTIALLY REVERSED. The suspension is affirmed, but it cannot be made effective any earlier than ten days from [redacted], the date of the Advance Negative Action Notice.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/3/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.