STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-53474 HHS
[redacted]

[redacted]

Appellant
_____/

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. The Appellant's cousin [redacted], represented him. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker (worker), was present as the Department's 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 was receiving Adult HHS. More specifically, he was receiving assistance with the following tasks: medication, housework, laundry, shopping, bathing, grooming, and meal preparation. (Exhibit 1, page 13)

2. The Appellant has been diagnosed with a left tibia/fibula fracture, ORIF, and left foot/ankle pain. (Exhibit 1, page 15)

3. On [redacted], the Appellant was informed that his HHS payments would be extended to [redacted]. But, at that time, the worker would need updated medical information regarding the Appellant's need for continued services. (Testimony of [redacted])

4. An annual assessment was conducted on [redacted]. At that time, the worker requested that the Appellant's physician complete an updated DHS 54-A medical needs form. (Exhibit 1, page 12; Testimony o[redacted]

5. The Appellant's physician completed two medical needs forms—one in [redacted] and one in [redacted]—but did not certify a medical need for any personal care services. (Exhibit 1, pages 18-19)

6. On [redacted], the Department issued an Adequate Negative Action Notice, suspending HHS payments, effective [redacted], based on the medical needs forms. (Exhibit 1, pages 7-9)

7. On[redacted], the Department received the Appellant's Request for Hearing. (Exhibit 1, pages 3-6)

8. After receiving the Appellant's hearing request, the worker reinstated the Appellant's HHS payment back to [redacted]. (Testimony of [redacted])

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 physician and may be provided by individuals or by private or public agencies.

Adult Services Manual (ASM 363) 9-1-2008, pages 2-5 of 24 addresses the issue of eligibility for Home Help Services:

> **ELIGIBILITY FOR HOME HELP SERVICES**
> Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.
>
> **Medicaid/Medical Aid(MA)**
> Verify the client's Medicaid/Medical aid status.
>
> The client may be eligible for MA under one of the following:
> - All requirements for MA have been met, **or**
> - MA deductible obligation has been met.

The client must have a scope of coverage of:

- 1F or 2F, **or**
- 1D or 1K (Freedom to Work), **or**
- 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rates by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:
  - •• Physician.
  - •• Nurse practitioner.
  - •• Occupational therapist.
  - •• Physical therapist.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

> The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services.
>
> If the medical needs form has not been returned, the adult services worker should follow-up with the client and/or medical professional.
>
> If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.
>
> Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.
>
> *Adult Services Manual (ASM 363) 9-1-2008, pages 7-9 of 24*

Policy requires that the worker obtain verification of a medical need for assistance from a Medicaid-enrolled provider in order to authorize HHS. Here, the Department eventually did receive two completed DHS 54-A medical needs forms from the Appellant's physician. However, neither form certified a medical need for services. (Exhibit 1, pages 18-19)

The Appellant's representative testified that she cannot understand why the Appellant's physician did not certify a medical need for services because he had just put a new boot on the Appellant's leg two weeks before the hearing and stated that the Appellant would be evaluated at his next appointment on [redacted]. The Appellant's representative stated that she was going to contact the Appellant's physician and ask him to fill out a new medical needs form.

In this case, policy is clear: verification is required from a Medicaid-enrolled medical professional certifying a medical need for services. The Department properly suspended the Appellant's HHS payments.

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) 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 failed to provide the Appellant with the required advance notice of at least ten days that his HHS payments would be suspended, as the effective date of the suspension was [redacted] (Exhibit 1, pages 7-9) 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 Advance Negative Action Notice—[redacted].

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: 11/24/2010

***** 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.