**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**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],

Docket No. 2011-30131 HHS
Case No. 28621571

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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared on his own behalf. Appellant's chore provider, [redacted], also testified on Appellant's behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Supervisor, and [redacted], Independent Living Services Worker, from the [redacted] DHS Office appeared as witnesses for the Department.

## ISSUE

Did the Department properly terminate payments for Home Help Services (HHS)?

## FINDINGS OF FACT

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

1. Appellant is a [redacted] year-old Medicaid beneficiary.

2. Appellant has been diagnosed with a physician as having diabetis, hypertensive cardiovascular disease, and hyperlipidemia. Appellant has also diagnosed himself as having high blood pressure, a recurring bleeding ulcer, and a slip disk in his back. (Exhibit 1, page 7).

3. Appellant has been receiving HHS since December of [redacted]. (Exhibit 1, page 6).

4. Appellant's case was most recently reviewed on [redacted].

(Exhibit 1, page 5).

5. Since that review, Appellant had been receiving 29 hours and 6 minutes of HHS per month, with a care cost of $[redacted]. (Exhibit 1, page 9).

6. Starting on [redacted], Appellant and his chore provider stopped receiving HHS payments. (Testimony of [redacted], Testimony of Appellant).

7. Appellant attempted to contact his HHS Worker [redacted], but was told she had retired. (Testimony of Appellant). Appellant's attempt to work with others was likewise fruitless. (Testimony of Appellant).

8. ILS Worker [redacted] was assigned Appellant's file in [redacted]. (Testimony of [redacted]).

9. On [redacted], the Department received Appellant's Request for Hearing. (Exhibit 1, page 4). In that request, Appellant stated that his case has not been monitored properly and that his chore provider has not received her check for months. (Exhibit 1, page 4).

10. ILS Worker [redacted] attempted a home visit with Appellant on [redacted], [redacted], but she was unable to meet up with Appellant on that day. (Testimony of [redacted]; Testimony of Appellant).

11. Both ILS Worker [redacted] and Appellant stated during the hearing that, now that they were in the same building, they can work together to schedule the home visit and assessment. (Testimony of [redacted]; Testimony of Appellant).

## 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 Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided 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 agencies.

In this case, the Department asserts that it stopped payments because Appellant's case had not been reviewed since [redacted]. Adult Services Manual 362 (12-1-07) (hereinafter "ASM 362") and Adult Services Manual 363 (9-1-08) (hereinafter "ASM 363") both address the review of service plans:

> **REVIEW**
>
> Update the comprehensive assessment and the service plan every six months. Review the adequacy of the service plan to assure it meets the client's current needs.
>
> Review eligibility for independent living services every 12 months, or sooner if the client's condition or circumstances warrant.
>
> The annual review requires:
>
> • MA eligibility verification, if relevant.
> • Comprehensive assessment.
> • Service plan.
> • Renewal of the medical needs (DHS-54A).
>
> > **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 must have a DHS-54A completed at the initial opening and then annually thereafter.
>
> (ASM 362, page 4 of 5)

> **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
>
> 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.

Documentation

Case documentation for all reviews should include:

- Update the "**Disposition**" module in ASCAP.

- Generate the CIMS Services Transaction (DHS-5S) from **forms** in **ASCAP**.

- Review of **all** ASCAP modules **and** update information as needed.

- Enter a brief statement of the nature of the contact and who was present in **Contact Details** module of ASCAP.

- Record expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.

- Record summary of progress in service plan by clicking on **Insert New Progress Statement in General Narrative** button, found in any of the **Service Plan** tabs.

**Annual Redetermination**

Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

- 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.

(ASM 363, pages 6-7 of 24)

Given the Department policies, the Department is correct in asserting that Appellant's case was overdue for review at the time of the termination decision. Appellant's case had not been reviewed since [redacted] and the policy manuals call for a review every six months.

The Department does not argue, nor does evidence suggest, that Appellant was at fault for the lack of timely review. It is undisputed that no one contacted Appellant about reviewing his case six or twelve months following the last review. Moreover, after Appellant's former worker retired, his case was not reassigned until after his HHS payments were terminated and he tried to get them reinstated.

Nevertheless, while Appellant may not have been at fault, the lack of review could constitute grounds for terminating his HHS. As provided in policy, ILS cases must be reviewed every six months, with additional steps being taken annually. ASM 362, page 4 of 5; ASM 363, pages 6-6 of 24. During those reviews, a worker should look at a number of details, including the comprehensive assessment, the service plan, the client's Medicaid eligibility, and the client's satisfaction. ASM 362, page 4 of 5; ASM 363, pages 6-6 of 24. Without the mandated reviews, the Department cannot know if a client remains eligible for services or if the current hours of HHS are reflective of his need for physical assistance.

However, even if Appellant's case was overdue for review, the Department could not terminate his HHS payments without the proper notice. As provided in ASM 362, notice is required whenever HHS payments are terminated:

**Advance Negative Action Notice (DHS-1212)**

If independent living services are denied or withdrawn, or if payment is suspended or reduced, the adult services worker must notify the client of the negative action.

The Advance Negative Action Notice (DHS-1212) is used and automatically generated on ASCAP when the following reasons are selected:

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

(ASM 362, page 3 of 5)

**TERMINATION OF HHS PAYMENTS**

Suspend and/or terminate payments for HHS in **any** of the following circumstances:

- The client fails to meet any of the eligibility requirements.
- The client no longer wishes to receive HHS.
- The client's provider fails to meet qualification criteria.

When HHS are terminated or reduced for any reason, send a DHS-1212 to the client advising of the negative action and explaining the reason. Continue the payment during the negative action period. Following the negative action period, complete a payment authorization on ASCAP to terminate payments.

If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action.

(ASM 362, page 4 of 5)

The Department argues that HHS payments were not terminated in this case and, instead, the time period for which payments were authorized simply ran out and no new payments could be authorized without a new assessment. However, such an argument ignores the fact that, regardless of how long it had been since Appellant's case was reviewed, HHS payments had been authorized through [redacted] and they were terminated prematurely. (Exhibit 1, page 6; Testimony of [redacted]; Testimony of Appellant).

In addition to being required to give notice of the termination, the Department was required to give sufficient notice. 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.

Moreover, because it was impossible for Appellant to request a hearing before the effective date of the negative action given the complete lack of notice, the Department implemented the termination of Appellant's HHS payments without giving him a chance to timely appeal that decision and have his benefits continued while his appeal was pending. As described above, ASM 362 provides that where HHS are to be reduced or terminated and the client requests a hearing before the effective date of the negative action, the Department is to continue the payments at the old level until a hearing decision has been made. ASM 362, page 4 of 5.

Given the clear policy and regulations regarding notice, the Department could not terminate Appellant's HHS payments without proper and sufficient notice. No such notice was given in this case and, in fact, Appellant was never notified of termination of HHS benefits until after filed a request for hearing. The termination of benefits on the basis that Appellant was overdue for a review is therefore invalid.

However, while the termination of HHS was made without proper and sufficient notice, this Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness. Certain criteria have to be met before HHS payments can be authorized. Accordingly, the Department must re-determine Appellant's eligibility for HHS from [redacted] onward and reimburse for benefits Appellant is otherwise entitled to.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly terminated Home Help Services without proper and sufficient notice.

**IT IS THEREFORE ORDERED** THAT:

> The Department's decision is REVERSED. The Department must re-determine Appellant's eligibility for HHS from [redacted] onward and reimburse for benefits Appellant is otherwise entitled to.

Steven Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/15/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.