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],

Appellant.
_____/

Docket No. 2011-39024 HHS
Case No. 15932981

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted] and [redacted], Adult Services Workers (ASWs) from the [redacted] County DHS Office, appeared as witnesses for the Department.

ISSUE

Did the Department properly suspend Appellant's 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 woman who has been diagnosed by a physician with bipolar disorder and borderline personality disorder. Appellant has also diagnosed herself as having arthritis in her back, hips and knees, schizophrenia, high blood pressure, thyroid problems, heart stents, a brain cyst, and trigger finger surgery. (Exhibit 1, page 9).

2. Appellant had been receiving 51 hours and 37 minutes of HHS per month, with a total care cost of $[redacted] per month. (Exhibit 1, page 11).

3. Beginning on [redacted], Appellant's Medicaid scope of coverage changed and she had a monthly deductible/spend-down of $[redacted]. (Exhibit 1, page 8).

4. On [redacted], ASW [redacted] sent Appellant an Adequate Negative Action Notice stating that Appellant's HHS is denied, she is not Medicaid

eligible, and she has a spend-down. (Exhibit 1, pages 6-7).

5. The notice also provided that Appellant's HHS was denied as of [redacted], [redacted]. (Exhibit 1, pages 6-7).

6. For the month of [redacted], Appellant's Medicaid became active on [redacted], [redacted], after she met her spend-down, and she received a prorated HHS payment for the remainder of that month. (Exhibit 1, page 12).

7. For the month of [redacted], Appellant's Medicaid became active on [redacted], [redacted], after she met her spend-down, and she received a prorated HHS payment for the remainder of that month. (Exhibit 1, page 12).

8. On [redacted], the Department received Appellant's Request for Hearing. In that request, Appellant states that she received a letter stating that she would no longer have a chore provider, but her provider performed services during the two weeks it took the letter to get to her. The request also states that she needs to talk to someone about her case. (Exhibit 1, pages 4-5).

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.

Home Help Services 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 private or public agencies.

Adult Services Manual 362 (12-1-07) (hereinafter "ASM 362") and Adult Services Manual 363 (9-1-08) (hereinafter "ASM 363") address the issue of eligibility for HHS:

> **Home Help Services (HHS)**
>
> **Payment** related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:
>
> • The client must be eligible for Medicaid.

- Have a scope of coverage of:

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

- The client must have a need for service, based on

  - Client choice, **and**
  - Comprehensive Assessment (DHS-324)

  indicating a functional limitation of level 3 or greater in an ADL or IADL.

- Medical Needs (DHS-54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:

  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

(ASM 362, pages 1-2 of 5)

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 of 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 (sic) that daily rate 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.

(ASM 363, page 7 of 24)

The Department must implement its programs in accordance with its policies. The Department policy listed immediately above mandates that a person must be eligible for Medicaid with a scope of coverage 1F or 2F; or the monthly spend-down must be met, in order to receive Home Help Services.

Here, the material facts are not in dispute. Since [redacted], Appellant has had a monthly deductible of $[redacted] that must be met before her Medicaid is active. (Exhibit 1, page 8). She met that spend-down in both [redacted] and [redacted], and she subsequently received prorated payments for those two months. (Exhibit 1, page 12). Based on that undisputed evidence and the applicable policies, those prorated payments were proper.

The primary issue in this case is not properly before this court. Appellant stated that she wished to dispute the calculation of her spend-down and when her Medicaid becomes active. It was explained that the Department of Human Services (DHS) office has jurisdiction over eligibility issues, not the Department of Community Health (DCH). Appellant has been advised to file a hearing request in the appropriate forum so that a separate hearing can be scheduled to address the Medicaid spend down/deductible determination with DHS. ASW [redacted] and ASW [redacted] also pledged to assist Appellant in speaking with her Medicaid worker. Appellant indicated she would file a request for hearing with DHS regarding Medicaid eligibility and, because Appellant's request for hearing also included the issues of DHS Medicaid eligibility and the amount of spend-down, Appellant's 90-day time period for requesting a hearing with DHS should be extended, but not longer than 90 days from the date of this hearing.

Appellant also challenges the lack of notice she received regarding her spend-down and the change in her payments. According to Appellant, she did not receive notice that her provider would not be paid until two weeks after [redacted], the day the payments were stopped. (Testimony of Appellant). As described above, the Adequate Negative

Action Notice issued by the Department on [redacted] stated that her HHS was "denied" as of that date. (Exhibit 1, pages 6-7).

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.

Here, as described above, the Adequate Negative Action Notice issued by the Department on [redacted] stated that Appellant' HHS was "denied" as of that date. (Exhibit 1, pages 6-7). Given that the effective date of the decision was the same day as the decision itself, the [redacted] Adequate Negative Action Notice issued by the Department clearly failed to provide Appellant with the required advance notice of at least 10 days that her HHS payments would be stopped until she met her spend-down. None of the exceptions to the advance notice requirement were present in this case and it appears that the Department erred.

The Department argues that it need not provide the required 10-day advance notice in this case because it denied Appellant HHS due to Appellant's inactive Medicaid and it cannot authorize payments where a client is not eligible for Medicaid. It is undisputed in this case that Appellant had not met her spend-down at the time of the Department's decision and, consequently, her Medicaid was inactive. Moreover, ASM 363 expressly provides:

> 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 (sic) that daily rate by the number of eligible days.
>
> (ASM 363, page 7 of 24)

However, the Department erred in characterizing its action as a denial suggests that Appellant's request for HHS was rejected and that is not the case here. Rather, the Department's negative action should be deemed a suspension. As provided in Adult Services Manual 362 (12-1-2007) (hereinafter "ASM 362") payments are "suspended"

when "payments stopped but case remains open." ASM 362, page 3 of 5. That is exactly what happened here: Appellant's HHS payments were stopped because she had a spend-down, but the case remained open so that she could receive a prorated HHS payment if and when she met her spend-down. Accordingly, as defined in policy, Appellant's HHS were suspended rather than denied.

The Department also argues that it cannot authorize HHS payments where the client's Medicaid is inactive, even if the client had been receiving HHS previously, but that argument must be rejected as well. With respect to cases where payments are suspended because the client no longer meets Medicaid eligibility requirements, ASM 362 describes a negative action period, during which payments are maintained and a client can request a hearing, between the date of the Department's decision and the date that decision takes effect:

> **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 (emphasis added by ALJ)

As discussed in that policy, when HHS payments are to be suspended because a client no longer meets the eligibility requirements, payments are to be continued during the negative action period. ASM 362, page 4 of 5. The presence of a negative action period where payments are maintained indicates that some time must pass between the date of the Department's decision and the date that decision is implemented. Similarly, ASM 362 provides that where HHS are to be suspended 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. That opportunity to appeal prior to the effective date of the suspension and have

payments maintained also indicates that that some time must pass between the date of the Department's decision and the date that decision is implemented. Here, Appellant was never given the opportunity to make such an appeal. Nor were she and her provider notified of the suspension before it took effect.

In any case where the Department suspends or terminates HHS payments, it presumably believes that the client is not entitled to HHS. Nevertheless, as required by policy and the applicable federal regulations, it still provides 10 days of advance notice before the negative action takes effect. This case should be no different.

Given the policy and regulations regarding notice, the Department cannot make the suspension of Appellant's HHS case effective any earlier than 10 days after the [redacted], [redacted] Adequate Negative Action Notice. However, it is undisputed that the Department did in fact make the suspension immediate despite the fact that there was improper notice. Accordingly, the Department must re-determine Appellant's eligibility for HHS during the period of [redacted] to [redacted], 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, finds that the Department properly suspended Appellant's HHS payments based on the available information. However, as the Department failed to provide the proper advance notice of the suspension and immediately stopped payments, the Department must re-determine Appellant's eligibility for HHS during the period of [redacted] to [redacted] and reimburse for benefits Appellant is otherwise entitled to.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED IN PART and REVERSED IN PART.

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

cc: [redacted]

Date Mailed: ____9/1/2011___

***** 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.