**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:

Docket No. 2011-52666 HHS
Case No. [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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], the Appellant, appeared on her own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker, [redacted] Department of Human Services (DHS), appeared as a witness for the Department.

## ISSUE

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

## FINDINGS OF FACT

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

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

2. The Appellant resided in [redacted] when she applied for HHS.

3. On [redacted], a [redacted] DHS Adult Services Worker (ASW) met the Appellant for an initial interview and determined a HHS case would be opened. (Exhibit 1, page 23)

4. On [redacted], mail was received for the Appellant's case requesting a HHS provider change to [redacted] with a start date of [redacted]. (Exhibit 1, page 22)

5. On [redacted], someone from [redacted] went into the [redacted] DHS office for an interview and completed paperwork to be enrolled as the Appellant's new HHS provider. (Exhibit 1, page 22)

6. On , a Services and Payment Approval Notice was issued to the Appellant indicating she was approved for HHS with a start date of , and a monthly care cost of . (Exhibit 1, pages 12-13)

7. On , a Services and Payment Approval Notice was issued to the Appellant indicating an HHS authorization with a start date of and monthly care cost of , noting that the payment increase was due to the agency rate and because laundry has been added. (Exhibit 1, pages 10-11)

8. Complete Home Services was enrolled as the Appellant's HHS provider effective . (Exhibit 1, page 28)

9. On , the ASW received a call purportedly from the Appellant regarding an error in HHS providers stating she never chose to go with an agency. (Exhibit 1, page 22)

10. On , the ASW called the agency asking them to bring the checks in, but this was not possible because the agency receives lump sum checks that include payments for multiple HHS cases. (Exhibit 1, page 22)

11. On , a call was made with both the Appellant and the agency on the line to try to confirm which HHS provider the Appellant wanted. The agency reported that the Appellant wanted to stay with them, but the call ended before the ASW could confirm with the Appellant which HHS provider she wanted. (Exhibit 1, page 21)

12. On , the ASW's supervisor received a message purportedly left by the Appellant requesting to stay with the agency as her HHS provider. (Exhibit 1, page 21)

13. On , the ASW and her supervisor called the Appellant to confirm the message. The Appellant explained that the agency and been helping out when her individual HHS provider had not been performing the services. She identified the agency as , reported that they started the end of April, and was okay with the agency being paid from the start date. The Appellant also reported the ex-HHS provider was her roommate, which had not been reported at the initial interview. (Exhibit 1, pages 20-21)

14. On , an Advance Negative Action Notice was issued to the Appellant indicating her HHS payments would be reduced to per month effective , because she lived with another adult and policy requires proration. (Exhibit 1, pages 7-9)

15. On [redacted], the Appellant moved to [redacted], in [redacted]. (Appellant Testimony)

16. On [redacted], the Appellant called the [redacted] DHS office and reported she had moved to [redacted] and she had a new HHS provider. (Exhibit 1, page 20)

17. On [redacted], the Appellant called the [redacted] office to complain her checks were not going to the correct HHS provider. The Appellant denied requesting the current provider and indicated the agency manipulated DHS into becoming the Appellant's HHS provider. The Appellant was instructed to come into the Wayne County DHS office with the new HHS provider to complete paperwork. (Exhibit 1, page 19)

18. On [redacted], the ASW's supervisor called the Appellant, who provided conflicting information and indicated someone had impersonated her. The ASW's supervisor informed the Appellant that no payments would be issued until the Appellant and the HHS provider are seen. An attempt was made to discuss transferring the case due to the Appellant's move. The Appellant indicated she would be filing a hearing request. (Exhibit 1, page 19)

19. No evidence was submitted indicating the Department ever issued any written notice or advance notice of a suspension to the Appellant regarding her HHS payments.

20. On [redacted], the ASW's supervisor's office received a call from the Appellant, who denied talking with the ASW's supervisor on [redacted] The Appellant was told she must be seen with the provider, and due to the distance from her new home, the case was transferred for the redetermination. (Exhibit 1, page 18)

21. On [redacted], the Appellant went to the [redacted] DHS office with her HHS provider. The Appellant's HHS provider was agitated over not being paid. The Appellant's HHS case had been reassigned to an [redacted] DHS ASW, but the file had not been received from [redacted] DHS. (Exhibit 1, pages 17-18)

22. On [redacted] the new ASW and an [redacted] Adult Services Manager had a case conference. The [redacted] DHS office was aware that the Appellant's case was a transfer case from [redacted] and a redetermination was needed. (Exhibit 1, page 17)

23. On [redacted], the new ASW completed an assessment while the Appellant and her HHS provider were in the [redacted] DHS office. Neither the Appellant nor her provider had a state ID with their current [redacted] addresses. The Appellant and her provider were advised to go to the Secretary of State office to have their addresses updated on

their IDs and to return to the DHS office on morning. A new application (342) was completed and a Medical Needs form (54A) was faxed to the Appellant's doctor. (Exhibit 1, page 17)

24. On , the DHS office received the transferred case file. (Exhibit 1, page 16)

25. On the Appellant and her HHS provider went to the DHS office. The HHS provider's ID had not been updated with her new address. The ASW agreed to complete the required home visit that afternoon if the Appellant's HHS provider would go and get her address updated with the Secretary of State upon leaving the office. (Exhibit 1, pages 14-15)

26. On , the ASW called and verified that the Appellant's HHS provider had gone to the Secretary of State to have her address updated. (Exhibit 1, pages 14-15)

27. On , the ASW attempted to complete a home visit. The Appellant was not home and did not return within the half hour the ASW waited. (Exhibit 1, page 14)

28. The ASW was eventually able to complete the home visit. (ASW Testimony)

29. On , HHS payments were authorized with a start date of , the first day the Appellant went to the DHS office. (ASW Testimony)

30. On , the Appellant's Request for Hearing was faxed to the Michigan Administrative Hearing System. (Exhibit 1, page 4)

## 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 private or public agencies.

Adult Services Manual (ASM 363, 9-1-08), pages 2-15 of 24 addresses the issue of assessments:

**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 client in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the client'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 department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

*Adult Services Manual (ASM) 363, 9-1-2008,*
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Adult Services Manual policy also addresses when the Advance Negative Action Notice form is to be issued:

**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.

*Adult Services Manual (ASM) 362, 12-1-2007,*
Pages 3 of 5

Further, 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.

An initial assessment of the Appellant's HHS case was completed on . (Exhibit 1, page 23) Accordingly, a six month review would have been due at the end of . However, the evidence shows there were concerns of fraud before the six moth review was due: the Appellant's statements that she never chose the agency as her HHS provider, that someone was impersonating her, and that she had not participated in some of the phone conversations with the DHS ASW and supervisor. (Exhibit 1, pages 18-22) In light of these concerns, the Department properly attempted to have another face to face interview with the Appellant and her HHS provider, prior to the six month review date. Face to face meetings are part of a comprehensive assessment that Adult Service Manual policy states is to be updated as often as necessary, but minimally at the six-month review and annual redetermination.

Given the concerns of fraud, the suspension of the Appellant's HHS payments until the Department could confirm who the Appellant wanted enrolled as her HHS provider would have been an appropriate case action had the required advance notice been given. No evidence was submitted indicating the Department issued any written notice or advance notice to the Appellant that her HHS payments would be suspended. The Adult Services Manual Policy provides for advance notice of a suspension to be issued utilizing the Advance Negative Action Notice form. Under the federal regulations, the Department is required to mail a notice at least 10 days before the date of the action in most cases. Even in cases of probable fraud by the recipient, the advance written notice is required, though only 5 days advance notice is required. The action taken by the DHS office to suspend the Appellant's HHS payments as of the , telephone conversation, with no written advance notice, can not be upheld.

The DHS office further erred by treating the Appellant as a new HHS applicant and only authorizing HHS payments as of the date she first went to their

office, [redacted]. It is not clear why the [redacted] DHS office had the Appellant complete a new application for the HHS program on [redacted]. (Exhibit 1, page 17) The [redacted] DHS office was aware this was a transfer case from [redacted] on [redacted]. (Exhibit 1, pages 17-18) While the [redacted] DHS office did not have the physical file initially, they had access to information on the DHS computer system and knew the Appellant's transferred HHS case was due for a review. (Exhibit 1, page 17) Further, the [redacted] DHS office had received the physical file before [redacted], when they authorized HHS payments for the Appellant retroactive to [redacted]. (Exhibit 1, page 16 and ASW[redacted] Testimony)

This ALJ understands the Department's concerns regarding fraud based on the case notes. However, the Department erred by implementing a suspension of the Appellant's HHS case with no written advance notice, and, by treating her case as a new application instead of a transferred case when she appeared at the [redacted] DHS office on [redacted].

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly suspended the Appellant's Home Help Services case because no written advance notice was issued.

**IT IS THEREFORE ORDERED** THAT:

> The Department's decision is REVERSED. The Department shall reinstate HHS payments to the Appellant for the period of the unnoticed suspension. Payments should be made retroactive to the date the [redacted] DHS office implemented the suspension until [redacted], the date the [redacted] DHS office authorized HHS payments for the Appellant.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/5/2011

***** 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.