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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 14-016796 HHS
Case No. [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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant personally appeared and testified. [redacted], Appellant's son and caregiver, appeared as Appellant's hearing representative and a witness on behalf of Appellant.

[redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker (ASW), and [redacted], Adult Services Supervisor (ASS) appeared as witnesses on behalf of the Department.

ISSUES:

1) Did the Department properly propose to close Appellant's HHS based on a failure of Appellant to be present for a review on [redacted]?

2) Did the Department properly stop Appellant's Home Help Services ("HHS") payments on [redacted]?

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 an [redacted] year old female beneficiary of the Medicaid and SSI welfare programs. Appellant has had an HHS case opened no later than [redacted]. (Exhibit A.16; Testimony).

2. On [redacted] the Department attempted a 6 month home visit. No one was at home and the ASW left. (Exhibit A.18).

3. On [redacted] an Adequate Negative Action Notice with the following action was mailed to Appellant: "Denied Please submit the logs for the pay period of [redacted], [redacted] and [redacted] by [redacted] to prevent negative action." (Exhibit A.6).

4. Appellant had timely delivered logs. (Testimony). The Department had failed to timely input the logs. (Testimony) No negative action took place regarding Appellant's logs. (Testimony).

5. On [redacted] the Department issued an Advance Negative Action Notice with an effective date of [redacted] with the following action: "Terminated due to failing to attend 6 month home visit; you must call specialist to reschedule before the negative action date to prevent negative action." (Exhibit A.10).

6. Due to Appellant contacting the Department before the negative action date, on [redacted] issued a home visit letter scheduled for [redacted]. As of the date of the administrative hearing, the Department had completed the in home review but had not completed its reassessment. (Exhibit A.5; Testimony).

7. On [redacted] MAHS received a request for an administrative hearing stating arguing that the Appellant's son was only 2-3 minutes late for the [redacted] home visit. (Exhibit A.18).

8. At the administrative hearing, the Department discovered that Appellant's payments were stopped [redacted], and that Appellant's "authorization end date was changed from [redacted] to 1[redacted]" without notice, and, without the local office's knowledge. (Exhibit A.19; Testimony).

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) 101, 11-1-11, addresses HHS payments. This general policy states in part:

> **Payment Services Home Help**
>
> Home help services are non-specialized personal care service activities provided under the independent living
>
> services program to persons who meet eligibility requirements.

> Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.
>
> *Adult Services Manual (ASM) 101, 11-1-2011, Page 1of 4.*

Adult Services Manual (ASM) 105, 11-1-11, addresses HHS eligibility requirements:

> **GENERAL**
>
> **…Home help payments cannot be authorized prior to establishing Medicaid eligibility and completing a face-to-face assessment with the client.**
>
> **Requirements**
>
> Home help eligibility requirements include all of the following:
>
> - Medicaid eligibility.
> - Certification of medical need.
> - Need for service, based on a complete comprehensive assessment (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
> - Appropriate Level of Care (LOC) status.
>
> ***
>
> **Necessity For Service**
>
> The adult services specialist is responsible for determining the necessity and level of need for home help services based on:
>
> - Client choice.
> - A completed DHS-324, Adult Services Comprehensive Assessment. An individual must be assessed with at least one activity of daily living (ADL) in order to be eligible to receive home help services.
>
> **Note:** If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services. …

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Adult Services Manual (ASM) 105,
11-1-2011, Pages 1-3 of 3

Adult Services Manual (ASM 120, 5-1-2012), pages 1-4 of 5 addresses the adult services comprehensive assessment:

INTRODUCTION

The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining need for services. The comprehensive assessment must be completed on **all open independent living services cases**. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements

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.
- The assessment may also include an interview with the individual who will be providing home help services.
- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- 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.
    - Use the DHS-27, Authorization to Release Information, when requesting client information from another agency.

- Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation; see RFF 1555. The form is primarily used for APS cases.

- Follow rules of confidentiality when home help cases have companion APS cases, see SRM 131 Confidentiality.

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Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking Medication.
- Meal Preparation and cleanup.
- Shopping.
- Laundry.
- Light Housework.

Functional Scale

ADLs and IADLs are assessed according to the following five-point scale:

1. Independent.
   Performs the activity safely with no human assistance.
2. Verbal Assistance.

Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some Human Assistance.
   Performs the activity with some direct physical assistance and/or assistive technology.
4. Much Human Assistance.
   Performs the activity with a great deal of human assistance and/or assistive technology.
5. Dependent.
   Does not perform the activity even with human assistance and/or assistive technology.

Home help payments may only be authorized for needs assessed at the 3 level ranking or greater.

An individual must be assessed with at least one activity of daily living in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services….

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for activities of daily living and instrumental activities of daily living.

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Time and Task

The specialist will allocate time for each task assessed a rank of 3 or higher, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a **guide**. The RTS can be found in ASCAP under the Payment module, Time and

Task screen. When hours exceed the RTS rationale **must** be provided.

An assessment of need, at a ranking of 3 or higher, does not automatically guarantee the maximum allotted time allowed by the reasonable time schedule (RTS). **The specialist must assess each task according to the actual time required for its completion.**

Example: A client needs assistance with cutting up food. The specialist would only pay for the time required to cut the food and not the full amount of time allotted under the RTS for eating.
IADL Maximum Allowable Hours

There are monthly maximum hour limits on all instrumental activities of daily living except medication. The limits are as follows:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven hours/month for laundry
- 25 hours/month for meal preparation

Adult Services Manual (ASM) 120, 5-1-2012,
Pages 1-5 of 5

Certain services are not covered by HHS. ASM 101 provides a listing of the services not covered by HHS.

Services not Covered by Home Help

Home help services must **not** be approved for the following:

- Supervising, monitoring, reminding, guiding, teaching or encouraging (functional assessment rank 2).
- Services provided for the benefit of others.
- Services for which a responsible relative is **able** and **available** to provide (such as house cleaning, laundry or shopping).
- Services provided by another resource at the same time (for example, hospitalization, MI-Choice Waiver).
- Transportation - See Bridges Administrative Manual (BAM) 825 for medical transportation policy and procedures.
- Money management such as power of attorney or representative payee.
- Home delivered meals.
- Adult or child day care.
- Recreational activities. (For example, accompanying and/or transporting to the movies, sporting events etc.)

Note: The above list is not all inclusive.

Adult Services Manual (ASM) 101, 11-1-2011,
Pages 3-4 of 4.

As a preliminary matter, Appellant objected to the 11/19/14 notice to stop payments due to the logs not being returned. General Policy and Procedure regarding providers, logs, and payment authorizations are found at ASM 135, 136, and 140. However, the Department testimony at the administrative hearing was that Appellant did not untimely return the logs, and that the witnesses at the hearing were not aware that the notice had been sent. Evidently, the notice was sent due to the failure of clerical staff to timely input the logs into the system. In any case, the testimony at hearing was that no action had been taken, and no action would be taken. The issue was resolved and thus, this Administrative Law Judge (ALJ) makes no substantive review of this action as it is moot.

ISSUE 1):

The Adult Services Requirements policy is found at ASM 115. This item addresses "Contacts" between the client and the ASW:

> The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.
>
> Adult Services Manual (ASM) 115, 5-1-2013, Page 3 of 3.

Policy regarding reviews is found in ASM 155. Relevant to the case herein, this policy states in part:

CASE
REVIEWS

> Independent living services (home help) cases must be reviewed every six months. A face-to-face contact is required with the client, in the home.

Here, A face-to-face or phone contact must be made with the provider at six month review and redetermination to verify services are being furnished. ASM 115, 5-1-2013, Page 1 In this case, the ASW testified that she went to Appellant's home for the 11/17/14 interview and there was no answer. When Appellant was leaving, a car pulled up with 5 men, and a man got out and attempted to knock on the ASW's car window. The ASW did not know who that individual was, and drove off.

At hearing, Appellant's son indicated that he was the individual and the ASW should have waited. The ASW responded by saying that she had no knowledge or information that the individual was Appellant's son or involved in her HHS case.

This ALJ find that the ASW's actions were not irrational, and in fact, reasonable under these facts. It is not unreasonable for any woman, or man, in the ASW's place that day to drive off when an unknown person is knocking on her car window when there are 5 men in the other car and that person is alone. In addition, as Appellant timely contacted the Department before the negative action took place, there was no suspension or termination due to the inability to complete the [redacted] home visit.

ISSUE (2)

As noted above, at the administrative hearing it was discovered that Appellant's payments stopped on [redacted]. Evidence of record indicates that no notice was issued. Moreover, the Department witnesses credibly testified that they had no documentary knowledge or information regarding this action, and that the 'local office' workers did not take this action.

Federal law is specific regarding when and the contents that notice must take in informing recipients of Medicaid benefits. The applicable authority states in part:

> Title 42: Public Health
>
> PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION
>
> Subpart E—Fair Hearings for Applicants and Beneficiaries
> §431.210 Content of notice.
>
> A notice required under §431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain
>
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
>
> (b) The reasons for the intended action;
>
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
>
> (d) An explanation of—
>
> (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
>
> (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

§431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

[78 FR 42301, July 15, 2013]

§431.213 Exceptions from advance notice.

The agency may send a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a beneficiary;

(b) The agency receives a clear written statement signed by a beneficiary 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 beneficiary has been admitted to an institution where he is ineligible under the plan for further services;

(d) The beneficiary'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 beneficiary's whereabouts become known);

(e) The agency establishes the fact that the beneficiary 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 beneficiary'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).

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993; 78 FR 42301, July 15, 2013]

§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 beneficiary; and

(b) The facts have been verified, if possible, through secondary sources

This federal requirement is found in the Department's manuals and policy. ASM 170 on Case Closures states in part:

CASE CLOSURE PROCEDURES

There are specific actions that must occur when closing an adult services case.

Note: Adult services specialists may chose to suspend payments, and delay case closure, if it appears the situation may be temporary.

Notification of the Negative Action

When home help services are terminated, suspended or reduced for **any** reason, a DHS-1212, Advance Negative Action Notice, must be generated in **ASCAP** and sent to the client advising of the negative action and explaining the reason for the action; see ASM 150, Notification of Eligibility to determine need for 10 business day notice of action.

A copy of the DCH-0092, Request for Hearing form is automatically generated from ASCAP when the DHS-1212 is printed. This must be forwarded to the client with the negative action notice.

Administrative Hearing Requests

Clients have the option to request an administrative hearing on all negative actions.

If the client requests a hearing before the effective date of the negative action, and the specialist is made aware of the hearing request, continue payments until a hearing decision has been made. If the specialist is made aware of the hearing request after payments have ended, payments must be reinstated pending the outcome of the hearing. Offer the client the option of suspending payments until after the hearing decision.

Note: When payments are continued pending the outcome of a hearing, the client must repay any overpayments if the Department's negative action is upheld. Initiate recoupment procedures by sending the client a DHS-566.

The Adult Services policy states that policy found in BAM 600 titled Hearings-is applicable. That policy states in part:

NOTICE REQUIREMENTS

All Programs

The application forms and each written notice of case action must inform clients of their right to a hearing. These include an explanation of how and where to file a hearing request, and the right to be assisted by and represented by anyone the client chooses.

The client must receive a written notice of all case actions affecting eligibility or amount of benefits. When a case action is completed it must specify:

- The action being taken by the department.
- The reason(s) for the action.
- The **specific manual item(s)** that cites the legal base for an action, or the regulation, or law itself; see Bridges

Administrative Manual (BAM) 220. BAM 600, 1-1-2015 Page 1.

The notice requirements can also be found in MAC R 400.901 and 400.902, in effect at the time of this action.

What the evidence shows is that Appellant's payments were stopped without notice, and without a hearings rights notice. As cited above, these notice requirements are clearly laid out in federal and state law, as well as Department policy. Also unknown to the worker was that Appellant's 'authorization end date was changed' pursuant to the Department's own evidentiary packet found on page 19. In addition, what was apparently a new review date was inconsistent the ASW's understanding of the actual review date for Appellant's case.

The purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record. The MDCH in this case, has delegated its authority to the DHS to administer the HHS program.

As noted above, the Department witnesses argued that the Department did not take the action here of stopping Appellant's payments without notice, but rather it was done by Lansing. The reality is that the "Department", the local office, "Lansing," and/or the Central Office all constitute the same Department. This ALJ is charged with responsibility to review the Department's actions; it is not relevant which division or even who personally took the action if it was taken under the authority of the Department and the requirements of the Medicaid program. While this ALJ finds the Department witnesses credible, this ALJ has no authority over internal Department communications or lack thereof. If an action was taken by the Department that is not in compliance with Department policy, and, not in compliance with federal law, then the ALJ is required to reverse.

Here, the evidence shows that the Department stopped Appellant's payments on [redacted] without notice, without an explanation, and without notification of fair hearing rights. Federal law found at 42 CFR 431.210 and 431.211, requires an advance negative action notice and notice of the right to a fair hearing. None of the exceptions found in 42 CFR 431.213 and .214 apply. As with the federal law and regulations, Department policy is clear that notice must be issued, and specifically, as applied to these facts, an advance negative action notice. See ASM 170; BAM 600; MAC R 400.901, 400.902. Failure to comply violates a beneficiary's due process and the requirements established by **Goldberg v**. **Kelly,** 397 U.S. 254 (1970). As the Department's action to stop Appellant's payments without notice and without notice of a right to a fair hearing, the action is not in compliance with federal law or state policy. The action must be reversed for the reasons set forth herein.

It is noted that there is no evidence in the case that the HHS program is a closed ended certification and that recipients are given notice that would stand in the stead of federal and state notice requirements. Because ASM policy does not require any written notice to beneficiaries at review if there is no change, there is no standard policy requirement(s) to give notice of begin and end dates to a beneficiary of the HHS program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides:

ISSUE 1) the Department did properly attempt to conduct a review of Appellant's HHS case on [redacted]. Accordingly, the proposed closure was correct but is moot as the Department subsequently reinstated the action.

ISSUE 2) that the Department's failure to issue notice to stop Appellant's payments for the HHS program on [redacted] was incorrect.

ACCORDINGLY, IT IS THEREFORE ORDERED REGARDING THE [redacted] PAYMENT STOP WITHOUT NOTICE THAT:

The Department's decision is hereby REVERSED for failing to issue notice of stopping payments on Appellant's HHS case effective [redacted], and

The Department is ORDERED to reinstate Appellant's payments from the date of closure, and issue any supplemental payments to Appellant to which she may be entitled.

Spodarek

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

cc: [redacted]

***** 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.