[redacted] * BEFORE MARY PEZZULLA,

APPELLANT * AN ADMINISTRATIVE LAW JUDGE

v. * OF THE MARYLAND OFFICE

[redacted] * OF ADMINISTRATIVE HEARINGS

[redacted] * OAH No.: MDH-[redacted]-10A-21-08404

[redacted] *

* * * * * * * * * * * * *

DECISION

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STATEMENT OF THE CASE

On December 31, 2020, [redacted] (Appellant) filed an application to receive Medical Assistance Long Term Care (MA-LTC) benefits. On February 16, 2021, the [redacted] (local department) denied the Appellant's application because the Appellant did not meet the requirements necessary to be approved for MA-LTC benefits. On April 23, 2021, the local department sent a second notice of denial entitled Notice of Ineligibility for Non-Financial Reasons, which is noted as a "[c]orrection to and supersed[ing] denial notice dated 2/16/2021." On or about March 18, 2021, the Appellant, through counsel, appealed the local department's action and filed a request for a hearing before the Office of Administrative Hearings (OAH) to contest the local department's determination. Code of Maryland Regulations (COMAR) 10.01.04.02A(1), .04A(1).

On May 6, 2021, I conducted a telephone hearing on the merits. [redacted] Esquire, and [redacted] Esquire, represented the Appellant, who was present for the proceeding. COMAR 10.01.04.12B. [redacted], Assistant Supervisor, appeared on behalf of the local department.

The contested case provisions of the Administrative Procedure Act, the procedures for Fair Hearing Appeals under the Maryland State MA Program, and the OAH Rules of Procedure govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2020); COMAR 10.01.04; COMAR 28.02.01.

ISSUES

1) Was the local department's Notice of Ineligibility to the Appellant legally sufficient?

2) If not, what remedy is available to the Appellant?

3) If so, was the local department's denial of the Appellant's application for MA-LTC benefits timely?

4) Was the local department's denial of the Appellant's application for MA-LTC benefits proper?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits offered by the Appellant:

App. Ex. 1 - Physician's Order for Skilled Nursing Care, January 16, 2020

App. Ex. 2 - [redacted] Physician's Orders for Nursing Care, January 16, 2020

App. Ex. 3 - [redacted] – Visit Summary, July 1, 2020

App. Ex. 4 - *Curriculum Vitae* of [redacted] M.D., undated

App. Ex. 5 - Affidavit of [redacted], M.D., April 27, 2021 with attached *Curriculum Vitae*, undated and letter from Dr. [redacted] to To Whom It May Concern, April 8, 2021

App. Ex. 6 - Notice of Denial for Participation in REM[1] from the Maryland Department of Health (MDH) to the Appellant, November 12, 2020

App. Ex. 7 - Appellant's Application for MA-LTC and attached cover letter, December 31, 2020

App. Ex. 8 - Email exchange between Mr. [redacted] and [redacted] local department, January 4 and 5, 2021

App. Ex. 9 - Memorandum from Ms. [redacted] to Mr. [redacted], January 5, 2021

App. Ex. 10 - Letter from Mr. [redacted] to Ms. [redacted], January 27, 2021

App. Ex. 11 - Email from Ms. [redacted] to Mr. [redacted], February 12, 2021

App. Ex. 12 - Email from Mr. [redacted] to Ms. [redacted] February 12, 2021

App. Ex. 13 - Denial letter from the local department to the Appellant, February 16, 2021

App. Ex. 14 - Hearing Request, March 18, 2021 with attached Authorization for Representation, August 14, 2020 and Durable Power of Attorney, March 15, 2010

App. Ex. 15 - Notice of Ineligibility for Non-Financial Reasons, April 23, 2021

App. Ex. 16 - Email from Ms. [redacted] to Mr. [redacted] undated

App. Ex. 17 - MA Nursing Home Transmittal No. 213, July 1, 2008

App. Ex. 18 - Community First Choice printout, undated

App. Ex. 19 - Community Personal Assistance Services printout, undated

App. Ex. 20 - Home and Community-Based Options Waiver printout, undated

App. Ex. 21 - Long Term Care Activity Report, DHMH[2] 257, January 12, 2021

App. Ex. 22 - Email exchange between Mr [redacted] and [redacted] Telligen, March 2, 2021

App. Ex. 23 - MDH Office of Eligibility Services Emergency Standard Operating Procedures, SOP # 20-05, revised November 16, 2020

[1] REM is the acronym for Maryland's Rare and Expensive Case Management program.
[2] The MDH was previously known as the Department of Health and Mental Hygiene, abbreviated as DHMH.

App. Ex. 24 - MDH Office of Eligibility Services Emergency Standard Operating Procedures, SOP # 20-08, revised November 16, 2020

App. Ex. 25 - Centers for Medicare & Medicaid Services, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, April 8, 2021

App. Ex. 26 - Maryland Medical Assistance Manual[3] (MA Manual[4]) Section 1000.1

App. Ex. 27 - MA Manual Section 400

App. Ex. 28 - MOV file on USB drive[5]

App. Ex. 29 - Department of Human Service Family Investment Administration Action Transmittal # 19-10, January 15, 1019

I admitted the following exhibit into evidence offered by the local department:

LD Ex. 1 - Local Department Appeal Summary with the following attachments:

- Fax Transmittal Cover Sheet from the local department to the OAH, April 28, 2021
- Request for Information from the local department to Mr. [redacted] April 23, 2021
- Denial letter from the local department to the Appellant, February 16, 2021
- Notice of Ineligibility for Non-Financial Reasons, April 23, 2021
- MA Manual Section 400.7, undated
- MA Manual Section 1000.1, undated
- COMAR 10.09.24.04, undated

Testimony

The Appellant testified on his own behalf and presented the testimony of the following witnesses:

- [redacted] M.D., accepted as an expert in pulmonology and critical care medicine;

[3] The MA Manual is a policy manual, issued by the Secretary of the MDH, to provide guidance in making MA eligibility determinations and to provide the Secretary's interpretation of the MDH's regulations. It is available to public for review on the Department's website, https://mmcp.health.maryland.gov/Medicaid%20Manual/Forms/AllItems.aspx. Although the MA Manual is available to the public, both parties felt the need to provide copies of various sections, which I admitted into evidence. As the MA Manual is the settled pre-existing policy of the MDH, I am bound by the MA Manual provisions to the same extent the MDH would be if it heard the case. Md. Code Ann., State Gov't 10-214(b) (2014).

[4] The local department also referred to the MA Manual as the MMAM.

[5] The USB drive that contains the MOV file also contains additional files. Only the MOV file, which is a video of the Appellant's daily care and which is approximately 10.47 minutes long was admitted into evidence.

- [redacted] R.N., accepted as an expert in nursing care of ventilatory care patients;
- [redacted] the Appellant's brother and power of attorney; and
- Ms. [redacted]

Ms. [redacted] also testified for the local department.

FINDINGS OF FACT

Having considered the evidence presented, I find the following facts, by a preponderance of the evidence:

1. The Appellant suffered a traumatic injury on or about [redacted] 2009, at which time he became paralyzed from the shoulders down, which was diagnosed as [redacted] quadriplegia.

2. On December 31, 2020, the Appellant applied for MA-LTC for an assistance unit of one person.

3. On the December 31, 2020 application, the Appellant listed his current address in [redacted] as his home address and noted that he has resided at that address for at least the past five years.

4. On the December 31, 2020 application, the Appellant answered the questions "If you live in a facility, what is the name of the facility?" with "N/A" meaning not applicable. (App. Ex. 7, LD Ex. 1).

5. Since his injury in 2009, the Appellant has continuously resided at his address in [redacted] and has not resided in a long-term care facility.

6. The Appellant is on a ventilator and requires twenty-four hour, around-the-clock care. He requires assistance with all activities of daily living.

7. The Appellant is currently receiving in-home nursing care through [redacted] which he can no longer afford to pay.

8. On January 4, 2021, the local department sent the Appellant a letter requesting additional information to be submitted by January 14, 2021 in order to process his application. This letter is sometimes referred to as Form 1052. The local department requested "DHMH 257 Medical certification initiated by the nursing home. (Note: MA LTC only pays the cost of care of a nursing home, please notify our office when the client is admitted to the nursing home)," as well as bank statements and proof of payment regarding the Appellant's mother's cost of care in the last five years. (LD Ex. 1).

9. On January 12, 2021, Ms. [redacted] completed a DHMH 257 with as much information as she could but did not complete the "Level of Care Certification." (App. Ex. 21).

10. Ms. [redacted] does not work for the MDH, nor does she work for Telligen, the company the MDH contracts with for its utilization review.

11. On February 16, 2021, the local department denied the Appellant's MA-LTC application. The reasons for the denial were listed as:

- Not meeting the program requirements to be in an institution;
- Reported assets were over the asset limit for the program;
- Not providing the information needed to establish eligibility; and
- Resources exceeding the maximum allowable amount of $2,500.00 with the amount of excess resources being $6,874.55.

12. On a date not established in the record, but after the initial denial on February 16, 2021, the Appellant provided additional financial documents to the local department for consideration.

13. On April 23, 2021, the local department issued a Notice of Ineligibility for Non-Financial Reasons to the Appellant, noting, "Correction to and supersedes denial notice dated 2/16/21." (App. Ex. 15, LD Ex. 1).

14. The April 23, 2021 notice informed the Appellant that based on his December 31, 2020 application, the local department determined he was ineligible for MA-LTC because he did not reside in a long-term care facility and he did not provide a completed DHMH 257 form from a long-term care facility. The notice stated that the decision was based on COMAR 10.09.24.04I(3)(e).

15. The Appellant is not seeking to reside in a long-term care facility and believes that it would be detrimental to his health to do so, as he would not have the same level of care he is currently receiving from the nursing staff of [redacted] and he would be potentially exposed to illnesses, such as COVID-19.

DISCUSSION

Burden of Proof and Applicable Law

As the party seeking to establish that the Department erred in its denial of his application for MA-LTC, the Appellant has the burden of proof in this matter. COMAR 28.02.01.21K(2)(a); *see Comm'r of Labor & Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) (quoting *Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959) (the burden of proof lies with the party seeking relief, or put differently, the party seeking to prove the affirmative of an issue before an administrative body)).

The standard of proof is by a preponderance of the evidence. Md. Code Ann., State Gov't § 10-217 (2014); *Bernstein*, 221 Md. at 232; COMAR 28.02.01.21K(1). To prove something by a "preponderance of the evidence" means "to prove that something is more likely so than not so," when all of the evidence is considered. *Coleman v. Anne Arundel County Police Dep't*, 369 Md. 108, 125 n.16 (2002); *see also Mathis v. Hargrove*, 166 Md. App. 286, 310 n.5 (2005).

MA-LTC

As a general matter, one seeking MA-LTC must submit an application to the local department and must meet both financial and non-financial eligibility requirements set forth in the Department's regulations. COMAR 10.09.24.04-1B(1), 10.09.24.05-1 through .05-5, 10.09.24.07, 10.09.24.08. An MA applicant is required to report all required information. COMAR 10.09.24.04I(3)(a). Once the local department receives the application, it establishes a "consideration period" based on the date of that application. COMAR 10.09.24.04H(1). To make a decision on an application, the local department is authorized to request that an applicant provide additional information to verify eligibility. COMAR 10.09.24.04I(3)(a)-(b). The Form 1052, which is used by the local department to request additional information to verify eligibility, instructs applicants that "If you fail to provide the information requested within six (6) months, you will need to file a new application." (LD Ex. 1). *See also* MA Manual, Section 400, Application Requirements (revised July 2012).

The local department is next required to inform the applicant or authorized representative in a written or electronic notice of the required information and verifications needed to determine eligibility, and the applicable pending time limit. COMAR 10.09.24.04I(3)(b). The applicant is required to provide the information early enough for the local department to make a decision within the time limits specified in the regulations. COMAR 10.09.24.04I(1), (3)(c). When an applicant fails to provide the required information and verification to determine eligibility within the applicable time frame, the local department is required to determine the applicant ineligible. COMAR 10.09.24.04I(3)(e). In cases where the applicant is actively attempting to establish his eligibility but has been unable to provide the required information through no fault of his own, the regulations require the local department, upon a proper request, to extend the time standards set forth

in the MA regulations to allow an applicant sufficient time to provide information. COMAR 10.09.24.04I(4)(a)(i).

Due Process of Law and Notice of Ineligibility

Notice and the opportunity to be heard are bedrock principles of due process.[6] *Goldberg v. Kelly*, 397 U.S. 254, 267–68 (1970) (requisite due process is an opportunity to be heard and adequate notice); *Golden Sands Club Condo., Inc. v. Waller*, 313 Md. 484, 487-88 (1988) (notice and "the guarantee of an opportunity to be heard" are "[a]t the core of the procedural due process right"). "[T]hese principles require that a recipient [of public benefits] have timely and adequate notice *detailing the reasons* for a proposed termination [of those benefits], and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally." *Goldberg*, 397 U.S. at 267–68 (emphasis added); *accord Knapp v. Smethurst*, 139 Md. App. 676, 703 (2001) ("A fundamental component of the procedural due process right is the guarantee of an opportunity to be heard and its instrumental corollary, a promise of prior notice.") (internal citations and quotation marks omitted).

"Unless a person is adequately informed of the reasons for denial of a legal interest, a hearing serves no purpose and resembles more a scene from Kafka than a constitutional process. Without notice of the specific reasons for denial, a claimant is reduced to guessing what evidence can or should be submitted in response . . . ." *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1980).

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[6] The Due Process Clause provides that "[n]o State shall...deprive any person of life, liberty or property, without due process of law...." U.S. Const. amend. XIV §1. "[Maryland courts] have recognized that property is a term that has broad and comprehensive significance; it embraces "everything which has exchangeable value or goes to make up a man's wealth—every interest or estate which the law regards of sufficient value for judicial recognition. Our notions of what constitutes property "may reasonably be construed to include obligations, rights and other intangibles as well as physical things." *Dodds v. Shamer*, 339 Md. 540, 548–49 (1995) (Internal citations and quotation marks omitted). Article 24 of the Maryland Declaration of Rights, which has been interpreted to guarantee due process for the people of this State, has also been interpreted as requiring that a defendant be given adequate notice before a claim against him may proceed. *See, e.g., Pickett v. Sears, Roebuck & Co.*, 365 Md. 67, 71 (2001).

> A notice required under § 431.206 (c)(2),[7] (c)(3), or (c)(4) of this subpart must contain -
>
> (a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action;
> (b) A clear statement of the specific reasons supporting the intended action;
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action[.]

42 C.F.R. § 431.210 (2019)[8]; *see also* Md. Code Ann., State Gov't § 10-207 (2014) (notice shall set forth the facts that are asserted as the basis of the action).

Positions of the Parties

The Appellant made multiple arguments as to why he is entitled to MA-LTC benefits. He first argued that the local department's February 16, 2021 denial did not properly address why his application was being denied, nor did it cite to the appropriate COMAR section regarding the denial. He next argued that the local department was required to make a decision on his application in thirty days, not forty-five days as the local department contends. As his application was submitted on December 31, 2020, that decision should have been issued on or before January 30, 2021. He also argued that even if the local department were correct in its interpretation that a decision was due in forty-five days and not thirty, the local department issued its decision on February 16, 2021, which is forty-seven days. Because of this, the denial should be reversed and MA-LTC benefits should be granted to the Appellant.

Lastly, the Appellant argued that even though he was not able to complete and submit the DHMH 257 form because the Appellant is not residing in a long-term care facility, he should still be eligible for MA-LTC care, which should be used to pay his at home nursing care. The Appellant argued that he is in a unique position in that it would be, not only detrimental to his health, but potentially life-ending, for him to enter a long-term care facility. The Appellant

[7] Notice must be provided upon a denial of eligibility for program benefits. 42 C.F.R. § 431.206(c)(2) (2021).
[8] The federal regulations governing MA are found in Title 42 of the Code of Federal Regulations (C.F.R.). All citations in the Decision are to the 2019 volume.

presented the expert testimony of Dr. [redacted] that were the Appellant to reside in a long-term care facility, it is more likely than not that he will need to be hospitalized due to medical complications with ulcers, urinary tract infections, COVID-19, and pneumonia. He argued that it is only because of the high quality of care that the Appellant is receiving from the nurses at [redacted] that he has been able to avoid numerous hospitalizations since his accident in 2009. He has attempted to apply for other MA programs but has been unsuccessful as he either does not qualify, or there are extremely long waiting periods. He argued that his inability to continue paying for his private nursing should not force him into a long-term care facility, which will likely lead to his death.

The local department argued that it properly denied the Appellant's December 31, 2020 application as he did not meet the requirements for MA-LTC. The local department explained that after receiving his application, the local department reviewed it and found that it was missing information that needed to be verified. In order to alert the Appellant to this missing information, the local department sent a letter on January 4, 2021, requesting additional documents from the Appellant by January 14, 2021. Included in that list of documents was the DHMH 257. The local department argued that the Appellant's application was denied on February 16, 2021, because in addition to missing the DHMH 257 form, the financial information available to it showed the Appellant had excess resources. The local department explained that while the Appellant provided additional financial documentation to show he was financially eligible, he did not provide the completed DHMH 257, as he was not residing in a long-term care facility, nor did he ever intend to reside in a long-term care facility. Because of this, the local department issued a corrected denial on April 23, 2021 that removed the financial elements as reasons for the denial and focused on the missing DHMH 257.

For the following reasons, I find that the Appellant has failed to prove that local department's Notice of Ineligibility was legally insufficient, or that the denial of his MA-LTC benefits was untimely or improper.

Analysis

Notice

I will first address the issue of adequate notice. Section 431.210 of the Code of Federal Regulations sets forth the requirements for adequate notice when the Department denies eligibility for program benefits. This section requires, in pertinent part, that the notice contain "[a] clear statement of the specific reasons supporting the intended action[.]" 42 C.F.R. § 431.210(b). Likewise, State Government Article section 10-207(b) requires that the notice state the "facts asserted" and "the pertinent statutory and regulatory sections under which the agency is taking its action." Md. Code Ann., State Gov't § 10-207(b)(1)-(2) (2014).

The February 16, 2021 Notice of Denial is a document totaling twenty-two pages.[9] Page three of the documents lists three reasons for the denial:

- because you do not meet the program requirement to be in an institution
- because the assets reported by you are over the asset limit for the program
- because you did not give the information needed to establish eligibility[10]

(App. Ex. 13; LD Ex. 1). Additionally, the "Supporting Rule" cited is COMAR 10.09.24.10A(2). (*Id.*). COMAR 10.09.24.10 is entitled "Determining Financial Eligibility for Institutionalized Persons" and COMAR 10.09.24.10A states, "Institutional status is presumed to begin on the first day of the first full calendar month in which the person is institutionalized and

[9] The Document begins on "Page 1 of 22" leading me to believe the documents consists of twenty-two pages. Although each party submitted a copy of this notice as an exhibit (App. Ex. 13 and LD Ex. 1), neither party included all pages. The Appellant's exhibit consists of six pages and the local department's exhibit consists of twelve pages.
[10] The reasons are not listed with bullet points in the documents, but are in bolded text. I used bullet points for ease of reading.

ends on the last day of the last full calendar month before discharge." Page four of the denial letter, in addition to relisting the previous three reasons for denial, adds an additional reason, stating, "You are not eligible because your resources exceed the maximum allowable amount of $2500. The amount of excess resources is $6874.55" and provides the "Supporting Rule" as COMAR 10.09.24.04. (App. Ex. 13 and LD Ex. 1). This section of COMAR is entitled "Application – General Requirements." COMAR 10.09.24.04.

Although the Appellant argued that this notice was not sufficient, I disagree. The Appellant's application was initially denied for multiple reasons, including not providing "information to establish his eligibility to the program" that had been previously requested in the local department's January 4, 2021 letter to the Appellant. Included in the January 4, 2021 letter was the request for the DHMH 257 form. Additionally, the Appellant's denial did not happen in a vacuum with no additional information provided to the Appellant other than the February 16, 2021 denial letter. Appellant's exhibits eight through twelve are all communications between the Appellant's counsel and the local department, requesting and exchanging documentation. Appellant's exhibit twelve is an email from Mr. [redacted] to a local department case worker, noting that Mr. [redacted] has been in contact with Ms. [redacted] "regarding [the Appellant's] circumstances and will be providing additional forms for your and her review." (App. Ex. 12).

It is also clear that there was additional communication and exchange of documents after the February denial and that the Appellant knew he needed to provide the local department with a completed DHMH 257 form. On March 2, 2021, Mr. [redacted] communicated with a Telligen representative, specifically regarding obtaining a completed DHMH 257 form, as evidenced in an email exchange with the subject of "Form 257 Approval." (App. Ex. 22). Additional communication is also evidenced by the April 23, 2021 Notice of Ineligibility that corrects and

superseded the February 16, 2021 denial. (App. Ex. 15 and LD Ex. 1). In an undated[11] email, Ms. [redacted] informed Mr. [redacted] that, "Attached is the corrected notice for [the Appellant], after completing the resource evaluation for 12/1/2020, his resources were within the asset limit for MA-LTC, however his case is still denied for not meeting the technical requirement of residing in a LTC facility per MMAM Chapter 10." (App. Ex. 16).

Finally, after receiving additional documentation from the Appellant, the local department provided a corrective notice on April 23, 2021, which clearly states that the Appellant is ineligible for MA-LTC because he does not reside in a long-term care facility and did not provide the DHMH 257 form and cites to COMAR 10.09.24.04I(3)(e). (App. Ex. 15; LD Ex. 1). COMAR 10.09.24.04I(3)(e) states, "When an applicant fails to complete the application form, or fails to provide the required information and verification to determine eligibility within the applicable time frame, the applicant shall be determined ineligible." Even if the February 16, 2021 denial was not facially sufficient, which I do not find to be the case, the Appellant offered nothing to support that the April 23, 2021 corrective notice was inadequate.

In reaching my conclusion that the local department's notice was legally sufficient, I am also guided by the Supreme Court's review of the constitutional sufficiency of the State of New York's notice in *Goldberg*. The Court concluded:

> Nor do we see any constitutional deficiency in the content or form of the notice. New York employs both a letter and a personal conference with a caseworker to inform a recipient of the precise questions raised about his continued eligibility. Evidently the recipient is told the legal and factual bases for the Department's doubts. This combination is probably the most effective method of communicating with recipients.

Goldberg, 397 U.S. at 268.

I am persuaded the Notice at issue here contains sufficient specificity and detail to make the Appellant aware of the "precise questions raised about his eligibility" and "the factual basis

[11] The email notes the date as "Today, 8:43 AM" but does not clarify the actual date.

for the Department's doubts." *Id.* It is clear that the Appellant knew the local department required the DHMH 257 form, as he took steps to obtain such a completed form. The fact that the local department also reviewed his application for his financial eligibility does not mean the local department did not require the DHMH 257 form as proof of the Appellant's need for institutionalized care as a general requirement of the application.

Timeliness of Denial

The Appellant argued that pursuant to COMAR 10.09.24.04I, the local department had to make a determination on the Appellant's application within either ten or thirty days. He further argued that as the February 16, 2021 denial letter is forty-seven days after the December 31, 2020 application date, the denial must be reversed. I disagree.

Analysis of this issue depends upon the interplay among several subsections of COMAR 10.09.24.04I and COMAR 10.09.24.04-1. COMAR 10.09.24.04I provides, in pertinent part, as follows:

> I. Processing Applications - Time Limitations.
> (1) When a written, telephonic, or electronic application is filed, a decision shall be made promptly but not later than:
> (a) 10 days from the date of application when filed with the local health department; or
> (b) 30 days from the date of application when filed with the Department or its designee, with the exception of the local health department.
>
> (2) The time standards specified in § I(1) of this regulation cover the period from the date of application to the date the Department or its designee sends a written or electronic notice of its decision to the applicant.
>
> (3) Information Required.
> (a) The applicant shall report all required information. When there is evidence of inconsistency with attested information given by the applicant and reported by the state and federal databases, the applicant shall be required to offer an explanation and appropriate verification to reconcile the inconsistency.
> (b) The Department or its designee shall inform the applicant or authorized representative in a written or electronic notice of the required information and verifications needed to determine eligibility, and the applicable pending time limit.

(c) The applicant or authorized representative shall provide all information and requested verification for the determination of nonfinancial and financial eligibility, including information relating to health insurance coverage or potential third-party payments, early enough for the Department or its designee to meet time limitations.

. . .

(e) When an applicant fails to complete the application form, or fails to provide the required information and verification to determine eligibility within the applicable time frame, the applicant shall be determined ineligible.

(4) Extension of Time Standards.

(a) The time standards specified in § I(1) of this regulation shall be extended to allow the applicant sufficient time to complete provision of information when:

(i) The applicant is actively attempting to establish his eligibility but has been unable to provide the required information through no fault of his own; or

(ii) There is an administrative or other emergency beyond the control of the Department or its designee.

(b) The Department or its designee shall document the reason for the delay in the applicant's written or electronic record. The extension of time will continue as long as the requirements of § I(4)(a) of this regulation are met. The Department or its designee shall deny Medical Assistance when these requirements cease to be met. When a subsequent application is made, eligibility and period under consideration shall be determined under § I(7), (8), (9), or (10) of this regulation.

. . .

(10) Reapplication After the Period Under Consideration Has Expired.

(a) A request for eligibility and application filed after the expiration of the period under consideration shall be considered a new application, and a new period under consideration shall be established.

(b) A part of the expired current period under consideration may not be converted to a retroactive period for purposes of determining eligibility. A part of the expired current period under consideration may constitute part or all of the 3 months before the month of application for purposes of post-eligibility deductions.

Additionally, COMAR 10.09.24.04-1[12] states, in pertinent part:

A. All of the requirements of Regulation .04 of this chapter shall apply with the exceptions stated in this chapter.

[12] This regulation applies to "MAGI Exempt Coverage Groups." "MAGI" stands for modified adjusted gross income, i.e., those applicants whose eligibility is determined based on income. The Appellant is MAGI-exempt because he is over sixty-five years old. COMAR 10.09.24.02B(1); COMAR 10.09.24.03E(4).

B. Application Filing and Signature Requirements.
(1) An individual who wishes to apply for Medical Assistance shall submit a signed application to the Department or its designee in the jurisdiction where his residence is located.

. . .

C. Period Under Consideration. Current eligibility shall have a period of consideration of a 6-month period beginning with the month of application for Medical Assistance, except as specified in Regulation .04H(3) of this chapter.

D. Processing Applications. When a written or electronic application is filed, a decision shall be made promptly but not later than:
(1) 45 days from the date of application in the case of determination of aged and blind individuals;

. . .

E. Extension of Time Standards.
(1) The time standards specified in Regulation .04I(1) of this chapter shall be extended to allow the applicant sufficient time to complete provision of information when the examining physician delays or fails to take a required action.
(2) Reactivation of an Application Following a Decision of Ineligibility for Reasons Other than Nonfinancial Factors, Excess Resources, or Excess Income.
(a) A request for current eligibility following the rejection of an application for reasons other than nonfinancial factors, excess resources, or excess income shall be considered a reactivation of the appropriate earlier application.
(b) The reactivation period shall:
(i) Apply to the earliest rejected application for which the period under consideration has not expired; and
(ii) Include the retroactive period associated with the current period.
(c) The applicant may establish eligibility for the current period, the retroactive period, or both, at any time during the reactivation period.
(3) Disposition of Application Following a Decision of Ineligibility. If an applicant is determined ineligible for the current period under consideration due to a nonfinancial factor or excess resources, the application shall be disposed of and the application date may not be retained. If the applicant reapplies, the process and the period under consideration shall be established under Regulation .04I(9) of this chapter.

In summary, the local department has forty-five days to make a decision on the eligibility of an applicant who is sixty-five years old or older. COMAR 10.09.24.04-1D(1). The Appellant listed his date of birth on his December 31, 2020 application as [redacted] 1953. (App. Ex. 7 and LD Ex. 1). At all times relevant to this matter, the Appellant was sixty-seven years old, meaning for MA purposes, he is MAGI-exempt.

The Appellant submitted his application on December 31, 2020. Forty-five days from December 31, 2020 was Sunday, February 14, 2021. Additionally, as I noted at the hearing, Monday, February 15, 2021 was President's Day, which is a State and federal holiday.[13] As the forty-fifth day fell on a Sunday and the forty-six day fell on a State holiday, the denial was due on the next day, which was February 16, 2021. The Appellant provided no MA regulation that would count the time differently. As such there is no specific MA regulation regarding time calculation, I next look to the OAH Rule of Procedure regarding calculation of time.[14] COMAR 28.02.01.04C(3)(b)notes that when computing time for filing, "If the last day falls on a Saturday, Sunday, holiday, or other day on which the Office is not open...the period runs until the end of the next day on which the Office is open..." I find the February 16, 2021 denial was timely as it was due in forty-five days, but the forty-fifth day was a Sunday and the forty-sixth day was a holiday.

I note, however, that even if the denial had been made in an untimely manner, the Appellant did not show any actual prejudice that the delay may have caused him. As discussed above, the denial, was based, in part, at least initially, on the Appellant's failure to provide information the local department requested to make an eligibility determination, specifically the DHMH 257 form. However, as discussed in the section below, the Appellant was never able to obtain a completed DHMH 257 form because he did not reside in a long-term care facility, was not planning on residing in a long-term care facility and, based on the testimony and evidence

[13] During the hearing I stated my intention to take official notice of the fact that Monday, February 15, 2021 was the holiday of President's Day. Neither party had an objection to this fact. Md. Code Ann., State Gov't §10-213(h)(2)(ii)(2014) provides that each party shall be given the opportunity to contest a fact that an ALJ intends to take notice of.

[14] COMAR 10.01.04.11 states that "If a conflict exists between this chapter and the Rules of Procedure of the Office of Administrative Hearings in COMAR 28.02.01, this chapter shall govern." I do not find that any conflict exists as COMAR 10.01.04, which is the procedures for Fair Hearing Appeals under the Maryland State MA Program, does not provide for computation of time.

presented in this case, believes that residing in a long-term care facility would be detrimental to his health, so is actively seeking to not reside in a long-term care facility.

If I had found the denial to be untimely, I would them have to determine the appropriate remedy for the local department's failure to provide the Appellant due process. In such a situation, I am guided by the *Accardi* doctrine. "The *Accardi* doctrine derives its name from the case of *Accardi v. Shaughnessy,* 347 U.S. 260, 267–68, 74 S.Ct. 499, 98 L.Ed. 681 (1954). It is a rule of federal administrative law, which generally provides that a federal administrative agency must follow its own rules and regulations." *Danaher v. Dep't of Labor, Licensing & Regulation,* 148 Md. App. 139, 174 (2002).

The Maryland Court of Appeals expressly adopted the *Accardi* doctrine in *Pollock v. Patuxent Board of Review*, 374 Md. 463 (2003). In *Pollock,* the Court held that a State administrative agency's failure to comply with its own rules, regulations and procedures can furnish a basis for reversal of the agency's action if the rule or regulations affect individual rights and obligations, or confer an important procedural benefit, and the individual suffers actual prejudice from the violation. 374 Md. at 503-04.

In this matter, since the Appellant is not seeking to actually reside in a long-term care facility and cannot provide the necessary documentation to the local department, no matter the date on which the denial would be issued, the Appellant will not have suffered an actual prejudice. I speculate, as the issue was not argued before me, that the Appellant would argue that his actual prejudice would be the delay and denial of payment for his at home nursing care. However, as discussed below, that is not a service provided by MA-LTC, although such a service may be available through other MA programs.

Denial of the Appellant's application for MA-LTC

The Appellant argued that due to the severity of his condition and the around the clock care that is necessary to keep him well, he is more susceptible to infection, which can be life threatening. As residing in a long-term facility would actually be detrimental to his health, he contended that his MA-LTC benefits should be used to pay for his at home nursing services. The Appellant presented Dr. [redacted]s expert testimony regarding his health and the fact that he has maintained his good health mostly due to the exceptional care that he has been provided by the nurses from [redacted] The Appellant testifed that he has tried to apply to other MA programs to cover his at home cost of care, but he either does not qualify, or the program has a waiting list, leaving him in a no-man's land for coverage of his nursing costs. He argued that as he cannot obtain the level of care in a nursing facility to keep him well and in the same condition he is while residing at home, the program should allow him to reside at home, while paying for his care. The local department countered that as the Appellant does not reside in a long-term care facility, and has no intention of residing in a long-term care facility, he is not an "institutionalized person," does not qualify for MA-LTC benefits, and will not be able to submit the DHMH 257 form.

I find that, in this matter, the local department's denial of the Appellant's MA-LTC application was appropriate. The Appellant provided compelling and heart wrenching testimony regarding his accident, his disability, his daily care routine, and why he should remain in his home, receiving the private nursing care that he has been receiving since 2009 and which has worked so well for him. The Appellant spoke passionately about his volunteer work with the [redacted] foundation, and how, before the COVID-19 pandemic, he would visit the [redacted] to speak with [redacted] I am sympathetic to the Appellant and do not discount his fears and concerns of how living in a long-

term facility could negatively affect him. However, in this matter, I am bound by the regulations and by the policy set forth in the MA Manual. Md. Code Ann., State Gov't 10-214(b) (2014).

On January 4, 2021, the local department requested the Appellant provide the DHMH 257 medical certification form by January 14, 2021. The January 4th letter noted that "MA LTC only pays the cost of care of a nursing home, please notify our office when the client is admitted to the nursing home." (LD Ex. 1). Although the Appellant submitted other documents to the local department, he did not submit a completed DHMH 257, as he was not in a long-term care facility and therefore was unable to obtain a certified DHMH 257. MA Manual section 1000.1 is entitled "Eligibility for Institutionalized Persons" and notes "Before determining a person's financial eligibility for a long-term care coverage category, it must first be determined that the person is considered institutionalized and that all non-financial requirements under COMAR 10.09.24.05 have been met." MA Manual section 1000.1. Additionally, section 1000.1(a) of the MA Manual defines "Institutionalized" as follows:

> A person aged 21 or older is considered "institutionalized" when he/she:
> - Resides in a licensed and certified Long-Term Care Facility (LTCF);
> - Has resided in an LTCF for a continuous period of 30 consecutive days or, if less than 30 consecutive days, is likely to remain there for 30 consecutive days; and
> - Has a medical need for Long-Term Care (LTC) as certified by the Utilization Control Agent on the DHMH 257.
>
> Note: If the [case manager] does not receive the DHMH 257 from the LTCF by the due date for the MA-LTC eligibility determination, the application should be denied due to lack of this verification, in accordance with the provisions of COMAR 10.09.24.04J(3)[15]—Information Required...

The Appellant simply does not meet this definition, and therefore does not qualify for MA-LTC benefits. As he is not an institutionalized individual, he is unable to obtain a certified DHMH 257. I sympathize with the Appellant that he has attempted to obtain coverage for his at-

[15] This is a typographical error in the MA Manual. The correct COMAR citation is 10.09.24.04(I)(3).

home nursing case through other MA programs, but has been unable to do so. His eligibility for those other programs, however, is not at issue before me.

As explained above, the local department is required to inform an applicant for MA-LTC in a written or electronic notice of the required information and verifications needed to determine eligibility, and the applicable pending time limit. COMAR 10.09.24.04I(3)(b). The local department complied with this requirement in its January 4, 2021 letter. The applicant is required to provide the information early enough for the local department to make a decision within the time limits specified in the regulations. COMAR 10.09.24.04I(1), (3)(c). When an applicant fails to provide the required information and verification to determine eligibility within the applicable time frame, the local department is required to determine the applicant ineligible. COMAR 10.09.24.04I(3)(e). The Appellant failed to provide the certified DHMH 257 and his application was properly denied.

CONCLUSIONS OF LAW

I conclude, as a matter of law, that the local department's Notice of Ineligibility was legally sufficient. *Goldberg v. Kelly*, 397 U.S. 254 (1970); 42 C.F.R. § 431.210(b) (2021); Md. Code Ann., State Gov't § 10-207(b)(1)-(2) (2014).

I further conclude, as a matter of law, that the local department's denial of the Appellant's December 31, 2020 MA-LTC application was timely. COMAR 10.09.24.04-1D(1); COMAR 28.02.01.04C(3)(b).

I further conclude, as a matter of law, that the local department's denial of the Appellant's MA-LTC application for failure to provide requested verifications was proper. COMAR 10.09.24.04I(3)(e).

ORDER

I **ORDER** that the April 23, 2021 decision of the [redacted] which corrected and superseded the February 16, 2021 decision, finding the Appellant ineligible for Medical Assistance Long Term Care benefits is **AFFIRMED.**

Signature Appears on Original

June 2, 2021
Date Decision Mailed

Mary Pezzulla
Administrative Law Judge

MP/da
192139

REVIEW RIGHTS

A party aggrieved by this final decision may file a written petition for judicial review with the Circuit Court for Baltimore City, if any party resides in Baltimore City or has a principal place of business there, or with the circuit court for the county where any party resides or has a principal place of business. Md. Code Ann., State Gov't § 10-222(c) (Supp. 2020). The original petition must be filed in the circuit court within thirty (30) days of the date of this decision, with a copy to [redacted], Office of the Attorney General, Suite 302, 300 W. Preston St., Baltimore, MD 21201. Md. Rules 7-201 through 7-210.

The petition for judicial review should identify the Maryland Department of Health, which administers the Medicaid program, as the agency that made the decision for which judicial review is sought. The address of the Maryland Department of Health should be included on the petition: 201 W. Preston St., Room 511C, Baltimore, MD 21201.

A separate petition may be filed with the court to waive filing fees and costs on the ground of indigence. Md. Rule 1-325. No fees may be charged to Medical Assistance Program recipients, applicants, or authorized representatives for transcription costs or for preparation or delivery of the record to the circuit court. The Office of Administrative Hearings is not a party to the judicial review process.

Copies Mailed To:

[redacted]