STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-5589 HHS
Case No. [redacted]
Load No. [redacted]

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, an in person hearing was held on [redacted], Appellant's representative, appeared and testified on behalf of Appellant. [redacted] (Appellant) appeared and testified. [redacted], represented the Department of Community Health (Department). [redacted] and [redacted], appeared and testified as witnesses for the Department.

ISSUE

1) Is Appellant entitled to a hearing on whether the Department properly reduced her Home Help Services payment effective [redacted]

2) Did the Department act properly by taking action to suspend Appellant's Home Help Services payment based on a failure to provide provider logs for the period of [redacted] through [redacted], and [redacted] through [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 a [redacted]-year-old Medicaid recipient who receives home help services (HHS).

2. Appellant was determined eligible for an HHS payment for the period of [redacted] to [redacted]. (Exhibit 1, p. 15)

3. Effective [redacted], Appellant's HHS payment was reduced to [redacted]. (Exhibit 1, p. 15)

4. Appellant filed a hearing request with the State Office of Administrative Hearings and Rules (SOAHR) to protest the reduction of her HHS payment and had her hearing before an Administrative Law Judge in [redacted]

5. On [redacted] SOAHR received another hearing request from Appellant.

6. In the hearing request received on [redacted] Appellant questioned why her HHS payment was reduced.

7. On [redacted], the [redacted], [redacted], sent Appellant notice that her HHS payment would be suspended effective [redacted], for the reason that she failed to submit "overdue chore provider logs." (Exhibit 1, p. 2)

8. Appellant's provider submitted all of the provider logs for the year [redacted].

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 (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 health professional and may be provided by individuals or by private or public agencies.

Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Customer choice.

- A complete comprehensive assessment and determination of the customer's need for personal care services.

- Verification of the customer's medical need by a Medicaid enrolled medical professional. The customer is responsible for obtaining

the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider.

The Medical Needs form must be signed and dated by one of the following medical professionals:

- Physician
- Nurse Practitioner
- Occupational Therapist
- Physical Therapist

The physician is to certify that the customer's need for service is related to an existing medical condition. The physician does not prescribe or authorize personal care services. If the Medical Needs form has not been returned, the adult services worker should follow-up with the customer and/or medical professional. If the case is closed and reopened within 90 days with no changes in the customer's condition, a new FIA-54A is not necessary.

Do **not** authorize HHS prior to the date of the medical professional signature on the FIA-54A.

Services not Covered by Home Help Services

Do **not** authorize HHS payment for the following:

- Supervising, monitoring, reminding, guiding 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;

- Services provided free of charge;

- Services provided by another resource at the same time;

- Transportation - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.

- Money management, e.g., power of attorney, representative payee;

• Medical services;

INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES
ADULT SERVICES MANUAL; ASM 363 1-1-2008

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment. Conduct a functional assessment to determine the customer'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 ADL's and IADL's 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.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater.

Time and Task The worker will allocate time for each task assessed a rank of 3 or higher, based on interviews with the customer and provider, observation of the customer'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.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication.

The limits are as follows:

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 hours/month for laundry
- 25 hours/month for meal preparation

INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES
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HOME HELP SERVICE PROVIDERS

Provider Selection

The customer has the right to choose the home help provider(s). As the employer of the provider, the customer has the right to hire and fire providers to meet individual personal care service needs.

The customer may receive FIA payment for home help services from qualified providers only.

The determination of provider qualification is the responsibility of the adult services worker.

Upon request, the adult services worker should assist the customer in obtaining a qualified provider.

The local office may maintain a resource file of qualified providers willing to assist HHS customers. The file may include such information as:

- Type of customer the provider is willing to work with;
- Training the provider has participated in;
- Past work experience;
- Hours the provider is willing/available to work;
- Type of services the provider is willing to perform.

Provider Criteria

Determine the provider's ability to meet the following minimum criteria in a face-to-face interview with the customer **and** the provider:

Age
- Appropriate to complete the needed service.

Ability
- To follow instructions and HHS program procedures
- To perform the services required
- To handle emergencies

Physical Health
- Adequate to perform the needed services

Knowledge
- How and when to seek assistance from appropriate others in the event of an emergency

Personal Qualities
- Dependable
- Can meet job demands including overtime, if necessary

Training
- Willing to participate in available training programs if necessary. HHS payment may be terminated if the provider fails to meet any of the provider criteria.

Provider Interview

Explain the following points to the customer and the provider during the initial interview:

- The provider is employed by the customer **not** the State of Michigan.
- A provider who receives public assistance **must** report all income received as a home help provider to the FIS/ES.
- The customer is the employer and has the right to hire and fire the provider.
- The customer is responsible for notifying the worker of any change in providers or hours of care.
- The services the provider is responsible for and has agreed to deliver including the frequency, amount and type of service.
- **The provider must keep a log of the services provided Personal Care Services Provider Log (FIA-721) and submit it on a quarterly basis.**
- The customer **must** sign the Authorization for Withholding of FICA Tax in Home Help Payments (FIA-4771).
- The customer **and** provider **must** sign the Home Help Services Statement of Employment (MSA-4676).

Providers considered as a business are exempt from signing the DCH-4676.

Personal Care Services Provider Log (FIA-721)

Each provider must keep a log of home help service provided. The FIA-721 is used for this purpose.

Indicate on the log which tasks the provider is approved to do based on the customer's HHS plan.

The provider must indicate what services were provided and on which days of the month.

The customer and the provider must sign the log when it is completed to verify that the services approved for payment were delivered.

The log must be submitted to the local office at least quarterly.

The adult services worker must initial and date the log upon receipt.

Retain the log in the customer's case record.

A separate log is required for each provider.

Other types of logs such as billings for services are acceptable in lieu of the FIA-721. Each bill must specify the service provided and the date(s) of service.

Home Help Services Statement Of Employment (MSA-4676)

The purpose of the Home Help Services Statement of Employment (MSA-4676) is to serve as an agreement between the customer and provider, which summarizes the general requirements of employment. The form is completed by the adult services worker as part of the provider enrollment process.

An employment statement must be signed by **each** provider who renders service to a customer.

The Statement:

- Confirms an understanding of the personal care services provided, how often services are provided, and wages to be paid.
- Requires positive identification of the provider by means of a picture ID.
- Documents an understanding by both parties that the customer, not the State of Michigan, is the employer of the provider.
- Stipulates that the customer must report any changes in the work schedule to the adult services worker.
- Instructs the provider to repay the State of Michigan for services he or she did not provide.
- Informs the provider that a Personal Care Services Provider Log (FIA-721) must be completed and returned to the worker on time to avoid delay in payment.
- Informs a provider receiving public assistance that this employment will be

reported to the Family Independence Agency.
- The customer and provider must sign the MSA-4676 statement indicating their understanding of the terms of the agreement.

Distribution of Employment Statement
- The adult services worker will make **two copies** of the completed and signed form.
- Give one copy to the customer and one to the provider.
- Place the **original** form in the customer's case record.

PAYMENT AUTHORIZATION

Payment Authorization System

Enter home help provider enrollments and payment authorizations on the Model Payment System (MPS) using the **Payments** module of the **ASCAP** system.

No payment can be made unless the provider has been enrolled on the MPS provider database. See the ASCAP user guide on the Adult Services home page.

HHS payments to providers must be:
- Authorized for a specific type of service, period of time and payment amount.
- Authorized to the person actually providing the service.
- Made payable jointly to the customer and the provider.

Any payment authorization that does **not** meet the above criteria must have the reason fully documented in the **Payments** module, exception rationale box, in **ASCAP**. The supervisor will document through the electronic approval process.

Adult Services Manual (ASM) 363, 1-1-2008

TERMINATION OF HHS PAYMENTS

Terminate payments for HHS in any of the following circumstances:

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

When HHS are terminated or reduced for any reason, send a FIA-1212 to the customer 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 customer 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.

Adult Services Manual (ASM)362, 1-1-2008

The Department representative provided a hearing summary, stating that the Department took action to suspend Appellant's HHS payment because of her failure to submit "overdue chore provider logs." The Department asserts that this negative action was done in accordance with program policy and should be affirmed. The Department witnesses appeared to be unsure of whether the HHS payment suspension was in effect at the time of the hearing. Initially, [redacted] testified that the action was pended; however, afterwards, she changed her testimony and said that the suspension did go into effect.

After the Department went forward and presented its case, Appellant's representative stated that she wanted a hearing to protest the reduction of Appellant's HHS payment. Appellant's representative claims that [redacted] never told her that she was required to submit any overdue provider logs. She stated further that Appellant's HHS payments have not been suspended. The Department representative objected to any testimony regarding the HHS reduction for the reason that the hearing request on the HHS reduction is untimely.

The last time that the Department reduced Appellant's HHS payment was [redacted] Appellant received notice of the reduction and filed a hearing request, protesting it. Appellant had a hearing before an Administrative Law Judge in [redacted] All parties agreed that the issue before that Administrative Law Judge was whether the Department properly reduced Appellant's HHS payment, and the previous Administrative Law Judge issued his final Decision and Order on this matter. Appellant's most recent hearing request was received on [redacted]

Appellant's hearing request, protesting the last reduction or any other previous reductions of her HHS payments is untimely. Clients retain the right to request a hearing on the Department's eligibility determination as long as it is done within 90 days from the date of the Department's written notice of eligibility, pursuant to 1979 AC Rule 400.904(4). Further, Appellant already had a hearing on the issue of the HHS reduction. This Administrative Law Judge does not have the authority to rehear the matter nor reverse the previous Administrative Law Judge's Decision and Order. Therefore, Appellant's hearing request, protesting the reduction of her HHS payment must be DISMISSED. Since Appellant's representative stated that she disagrees with the previous Administrative Law Judge's Decision and Order, a copy of her hearing request was forwarded to SOAHRS who will determine if she is entitled to a Rehearing.

During the hearing, Appellant's representative made it clear that she disputes the Department's determination that she failed to submit provider logs in a timely manner. Appellant was entitled to a hearing on whether the Department's action to suspend her HHS payment was done in accordance with the applicable law and policy, and this Administrative Law Judge has jurisdiction to resolve this issue. Appellant had several copies of provider logs with her at the hearing and offered them into evidence to establish that she submitted them to the Department as required.

[redacted], Appellant's [redacted], testified that Appellant failed to submit provider logs for the period of [redacted] through [redacted], and [redacted] through [redacted] Under questioning by this Administrative Law Judge, [redacted] testified that she received all of the provider logs that were due for the year [redacted].

This Administrative Law Judge cannot uphold the Department's action to suspend Appellant's HHS payments effective [redacted] due to a failure to submit provider logs that were due in the years [redacted] through [redacted]. Department policy does state that HHS providers are required to keep a log of the services provided on a Personal Care Services Provider Log and submit the logs to the Department on a quarterly basis. If a provider refuses to submit a provider log of the services that he/she provided, the Department is required to close the case on the basis that the provider is no longer meeting the provider qualification criteria. (ASM, Item 363) However, in this case, based on the evidence on the record, Appellant received a HHS payment during the period of [redacted] through [redacted] after the Department determined that she continued to meet the eligibility criteria for HHS. The Department failed to provide a reasonable explanation for why the Adult Services Worker is trying to obtain several provider logs that should have been received in [redacted] through [redacted] or why the worker failed to take immediate action to close Appellant's HHS case if she determined that Appellant's provider was not submitting provider logs as required by policy. [redacted] and [redacted], the [redacted], testified that they need the requested provider logs for their federal audit. However, they failed to provide any law or policy which states that it is Appellant's responsibility to assist the Department with obtaining the documentation that it needs to comply with a federal audit of the Department. Further, clients have only 90 days from the date of notice of the Department's HHS eligibility

determination to request a hearing on that eligibility determination. A timely hearing request gives the Department reasonable time to investigate the matter and obtain the necessary evidence that it needs to defend the Department's action and meet its burden of going forward and establishing that the Department acted properly. Likewise, the Department is required to comply with Department policy and terminate a client's HHS case in a timely manner and provide the client with timely notice once it becomes aware that the client no longer meets the HHS eligibility criteria. Not doing so, prejudices the client by materially impairing the client's ability to meet his/her burden of establishing that he/she has met the HHS eligibility at all times relevant to the matter to be resolved. Lastly, the fact that the Department does not have the logs in question does not establish that Appellant or her provider failed to submit them. The Department witnesses never submitted any documentation from the time period in question which establishes that it made a timely request of the logs from Appellant. The Department's evidence fails to rule out the possibility that the logs were misplaced by a Department employee after receipt. In conclusion, the Department's action to suspend Appellant's HHS payments due to "overdue chore provider logs" must be Reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department acted improperly by taking action to suspend Appellant's HHS payments effective [redacted], due to "overdue chore provider logs" logs for the period of [redacted] through [redacted], and [redacted] through [redacted].

IT IS ORDERED that:

1) Appellant's hearing request, protesting the reduction of her HHS is DISMISSED; and

2) The Department action to suspend Appellant's HHS payments is REVERSED. It is further ORDERED that the Department shall issue any HHS payment that Appellant did not receive as a result of the suspension, if she meets all other HHS eligibility criteria.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/24/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.