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]

Docket No. 2011-8077 HHS
Case No. 33483041

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented himself at the hearing.

[redacted], represented the Department. [redacted], was present on behalf of the Department. [redacted], was present on behalf of the Department. Department witness, [redacted], was present and testified at the hearing.

ISSUE

Did the Department properly terminate Home Help Services (HHS) payments to the Appellant?

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary who has been participating in the Adult Home Help Services program.

2. Narrative notes contained in the Appellant's file indicate on [redacted] the DHS worker acknowledged a message from the Appellant's provider indicating she did not want to provide services to the Appellant. Thereafter, the Appellant telephoned the worker to inform her they had worked it out and not to make changes. (Department Exhibit A, page 12)

3. On [redacted], the Appellant, his roommate and his [redacted] were present at the Department of Human Services office. (testimony of [redacted])

4. The Appellant's [redacted] was in an interview room with the Adult Services Worker to effectuate her enrollment as the Appellant's [redacted]. (Department Exhibit A, page 12)

5. While the provider was in the interview room with the Appellant's worker, the Appellant walked through a door that had been opened for another client, passed the security guard and loudly demanded to be let into the interview room. (Department Exhibit A, page 12)

6. The Appellant walked unassisted from the lobby, through the open door and to the interview room at a pace sufficient to pass the security guard who had opened the door for another person. (testimony of [redacted])

7. Case records kept by the Department indicated the Appellant was in need of physical assistance for his mobility and reliant upon a wheelchair. (Department Exhibit A)

8. The Appellant did disrupt the operations at the DHS office with his conduct, thus was escorted out of the building. (Department Exhibit A, page 12)

9. The Appellant denies being present at the DHS on the date at issue. He asserts he has been mistaken for another individual, who he knows. (Appellant's testimony)

10. On [redacted], DHS management instructed the Adult Services Worker to stop HHS payments in the Appellant's case effective immediately. (Department Exhibit A, page 12)

11. The Department sent a negative action Notice to the Appellant terminating his Home Help Services grant. The reason cited is "unable to verify continuation of services." (Department Exhibit A pages 5 & 6)

12. The negative action Notice sent the Appellant was dated [redacted]. The effective date of the action the Notice states is [redacted]. (Department Exhibit A, pages 5 & 6)

13. The Department effectuated the termination of HHS payments retroactively to [redacted], despite notifying the Appellant the effective date was [redacted]. (testimony from Department at hearing)

14. The Appellant requested a timely hearing, on [redacted]. (Department Exhibit A, page 3)

15. The now former provider thereafter wrote a letter to the Department stating she had not been providing services and wanted to discontinue working for the Appellant and his [redacted]. The letter is undated. It is date stamped received at the Department of Human Services [redacted]. (Department Exhibit A, page 14)

16. There is no evidence of record the Department sought to verify whether services were being provided or not prior to sending the negative action Notice terminating services.

17. The Department reinstated payments to the Appellant for HHS services effective [redacted] after he hired a new provider.

18. The Department's comprehensive assessment of the Appellant has him ranked in need of physical assistance (either 3 or 4) for bathing, grooming, dressing, toileting, transferring, mobility, housework, laundry, shopping, and meal preparation. The Department authorized monthly payments in the amount of $[redacted] per month. (Department Exhibit A, pages 16 &18)

19. The Department records indicate the Appellant has degenerative arthritis in his left knee and asthma. There is another indication he has "multiple injuries." (Department Exhibit A, page 17).

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 physician and may be provided by individuals or by private or public agencies.

ELIGIBILITY FOR HOME HELP SERVICES

Home help services (HHS) are defined as those, which the Agency is paying for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid (MA)

Verify the customer's Medicaid/Medical aid status.

The customer may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**
- MA spend-down obligation has been met.

Adult Services Manual (ASM) 9-1-2008

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.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

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
- 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 the 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.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs 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.

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements. If there is a need for expanded hours, a request should be submitted to:

* * *

Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the Client does not perform activities essential to the caring for self. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.
- The kinds and amounts of activities required for the Client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client does not perform. Authorize HHS only for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. Unable means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS-54A.

- Do not authorize HHS payments to a responsible relative or legal dependent of the client.
- The extent to which others in the home are able and available to provide the needed services. Authorize HHS only for the benefit of the client and not for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for the same time period).

Good Practices Service plan development practices will include the use of the following skills:

- **Listen actively** to the client.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for **congruency** between case assessment and service plan.
- Provide the necessary supports to **assist** clients **in applying for resources**.
- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.
- **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

REVIEWS

ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review
Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

Documentation
Case documentation for all reviews should include:

- Update the **"Disposition"** module in ASCAP.
- Generate the CIMS Services Transaction (DHS-5S) from **forms** in **ASCAP**.
- Review of **all** ASCAP modules **and** update information as needed.
- Enter a brief statement of the nature of the contact and who was present in **Contact Details** module of ASCAP.
- Record expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- Record summary of progress in service plan by clicking on **Insert New Progress Statement in General Narrative** button, found in any of the **Service Plan** tabs. **Annual Redetermination** Procedures and case documentation for the annual review are the same as the six month review, with the following additions:
  Requirements:
  - A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
  - A new medical needs (DHS-54A) certification, if home help services are being paid.
    Note: The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.

- A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

ELIGIBILITY FOR HOME HELP SERVICES
TERMINATION OF HHS PAYMENTS

Suspend and/or terminate payments for HHS in **any** of the following circumstances:

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

When HHS are terminated or reduced for any reason, send a DHS-1212 to the client advising of the negative action and explaining the reason.

Continue the payment during the negative action period. Following the negative action period, complete a payment authorization on ASCAP to terminate payments. If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action.

See Program Administrative Manual (PAM) 600 regarding interim benefits pending hearings and Services Requirements Manual (SRM) 181, Recoupment regarding following upheld hearing decisions. (emphasis added by ALJ)

Adult Services Manual (ASM) 9-1-2008

The Department sought to terminate the Appellant's services payments, thus sent a Notice. It informed the Appellant of an effective date, [redacted]. However, uncontested testimony at hearing establishes the Department actually took action retroactively back to [redacted]. The Code of Federal Regulations addresses Notice requirements below:

§ 431.211 Advance notice.

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

§ 431.213 Exceptions from advance notice.

The agency may mail a Notice not later than the date of action if—

(a) The agency has factual information confirming the death of a recipient;
(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);
(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the recipient's physician;
(g) The Notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance Notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

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

The events of the office visit on [redacted], led to the Department's determination to terminate or suspend payments. A Notice of each action was sent to the Appellant and ultimately his benefits were reinstated, thus it was effectively a suspension of benefits. During the in office visit the worker personally witnessed the Appellant walk unassisted. This is noted in the case narrative and was also testified to by the [redacted] who was present. The Appellant contested this at the hearing, denying he was even in the office on the date at issue. His assertion is not found credible by this ALJ. It lacks credibility when compared to the testimony of the [redacted] and contemporaneous documentation of the event in the Department records. Furthermore, it lacked credibility in part because the Appellant himself testified he was mistaken for a specific named person while at the same time asserting he was not present. How would he be in a position to know who he was mistaken for if he was not there, or describe the other person as an older gentleman? The worker's direct observation of the Appellant's mobility contradicted her belief the Appellant required physical assistance with mobility. This belief was undoubtedly based at least in part by the fact that the Appellant has a wheelchair. This is also noted in documents contained in the case file. The worker thereafter consulted with her supervisor, who instructed her to stop payments on the Appellant's case immediately. While normally termination of services is based upon a comprehensive assessment that is not the exclusive basis for a suspension or termination of services. The Department is entitled to act on facts gleaned from other circumstances than a formal comprehensive assessment or case review. Here, as the Appellant's ability to ambulate and use his upper extremities was an apparent surprise to the worker, she sought to address it immediately and consulted her supervisor. She identified an incongruity between services being provided and apparent physical ability that was stark and profound. Policy directs her to monitor for incongruity. The suspension or termination of benefits in this circumstance is upheld. However, the process by which termination was effected was incorrect.

The Department took action effective on [redacted], despite informing the Appellant in writing the effective date would be [redacted]. The effective date of the Notice was given in advance, as is required by Department policy and both state and federal law; however, the Department's actions did not comply with any of the three sources of authority. The error with respect to the Notice is that the Department's action did not comport with what it informed the Appellant it would do, in writing. Neither law nor Department policy supports effectuating a termination date earlier than indicated on the Notice mailed to a beneficiary. It is impermissible retroactive action. The Department does not cite any authority for termination of payments retroactive to a date cited on a legal Notice, nor was one found by this ALJ. Risking redundancy, fundamental fairness dictates this ALJ to stress to the Department that the effective date of a Notice binds them to that date. The Department's decisions, actions and legal notice must all be guided by its own policy, Michigan and federal legal requirements.

These decisions are made and executed by its workers and supervisors, however must be driven by its own written policy. A Department supervisor cannot authorize the Department worker to disregard the Notice requirements contained in law and policy and effectuate an action earlier than noticed. The Department's own policy instructs them to continue payments during the negative action period and during the pendency of a hearing if a timely hearing request is made. If the Department ultimately prevails at hearing, their remedy is to seek recoupment. The Department skirted the recoupment process by effecting a termination not only prior to the date stated on its own notice but retroactively.

The Department sought to introduce evidence of the reason for retroactive termination of payments at hearing. It did submit a statement from the provider that she was not providing services to the Appellant and has not for three months. Even if the statement had been made in writing on [redacted], and provided to the Department, the Department would have had to follow the policy relative to proper Notice of termination or suspension of benefits and then sought recoupment for overpayments. It is never permissible to end payments retroactively, even where fraud is suspected. Furthermore, the information from the provider was provided in writing to the Department in [redacted], thus it was not a basis for the Department's decision on [redacted]. This evidence cannot be considered by this ALJ in determining whether the Department's action was proper because it was produced after the event, thus did not influence the Department on the date of the determination. It may have been material to a recoupment action had the Department sought to take this action. It is irrelevant evidence at this hearing.

The beneficiary is entitled to know the reason for suspension or termination of his benefits. The first sentence of the Notice sent to the Appellant indicates "following a review of the Home Help Services that you are currently receiving, it has been determined that the Home Help Services will be terminated." No evidence was placed into the record indicating a review took place. Department policy states what Department actions comprise a review. Not every action must be based upon a complete case review, however, the legal Notice mailed the beneficiary should be accurate. It is flawed in the respect that it cites to a review that did not take place. The determination made was not following a case review, rather, it was following an incident in the office that illustrated incongruity in services being provided compared with apparent ability or gave rise to a suspicion of fraud. The Notice should have cited suspicion of lack of need for services if that was in fact the case. The Notice continues by providing a statement of the reason(s) for the case action which is vague. Given the context of the scene at the office, it does allude to services not being provided. Given the context, perhaps the Department suspected the Appellant was engaged in fraud. If so, it was not explicitly stated on the notice sent. Even if fraud was the basis for termination a 5 day advance notice period is still required by the federal law. The worker is not to blame for doing as instructed by her supervisor, however, the Department's impermissible retroactive action cannot be found to comport with legal requirements.

The next issue that arises due to the early termination of services payments is the timely request for hearing made by the Appellant. In this case, the Notice was mailed [redacted]. The policy provides the Department must continue payments pending the outcome of a hearing where the beneficiary makes a timely hearing request, prior to the effective action date of the Notice. The effective date on the Notice itself is [redacted]. The hearing request was received [redacted], thus it was timely. The Department erred by failing to continue payments pending the outcome of the hearing. Recoupment is the Department remedy in cases of overpayment and is specifically cited in policy about Notice.

The Department termination based upon the direct observation of the Appellant walking briskly and pounding his fists does support termination of Home Help Services. As discussed above, the Department's action in effectuating the termination prior to its own Notice date is not supported by policy. The only reason payment benefits cannot be ordered payable back to [redacted], under these circumstances is the fact that no services were actually provided during this period. This ALJ must be able to find credible evidence in the record that the Appellant continued receiving services pending outcome of the hearing in order to rectify the Department errors. The payments are for the chore provider for services rendered, not services that should have been authorized. The Appellant's right to have services continue pending a hearing due to timely filing of the hearing request does not mean he is entitled to payment assistance for services that were not rendered. While the Appellant asserted the services were in fact rendered and attempted to evidence that by proffering an "affidavit" from his chore provider, his assertions are not credible. The "affidavit" is not attested to by a notary and a lay person's glance at the signature reveals the purported signature of the provider differs substantially from other signed documents produced by the Department in response to the "affidavit." It is not found credible by this ALJ and will not be given any weight. The evidence produced is insufficient to persuade this ALJ services were rendered during the pendency of this hearing, thus no retroactive payments will be ordered issued to his former provider. While the Department's errors in the case are substantive and potentially quite profound, the fact of the matter is services cannot be rendered retroactively.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department acted properly to terminate the Home Help Services case of the Appellant even while failing to abide by its own written Notice.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/10/2011

***** 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.