STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2012-9380 REM
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This case is returned to the Michigan Administrative Hearing System (MAHS) pursuant to order of the Honorable [redacted], [redacted] Judicial Circuit Court, [redacted] County issued [redacted].

After due notice, a hearing commenced on [redacted] and was completed on [redacted]. Attorney [redacted], appeared on behalf of the Appellant. [redacted], the Appellant, appeared and testified. [redacted], daughter, [redacted], neighbor, and [redacted], caregiver, appeared as witness for the Appellant. [redacted], Appeals Review Officer, represented the Department on REMAND. Deputy [redacted], [redacted] County Sherriff's Office, [redacted], Social Worker, [redacted] Hospital, [redacted], Adult Services Worker ("ASW") and [redacted], [redacted] Program Manager, appeared as witnesses for the Department.

ISSUE

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

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 had been authorized for Home Help Services.

2. The Appellant has a history of multiple medical conditions including: severe back and neck pain with various documented spinal impairments, lumbar spinal fusion, radiculopathy, torn right wrist tendon, carpal tunnel syndrome, anxiety and panic attacks, occlusive disease changes in

bilateral lower extremity arteries, and narrowing and stenosis in carotid arteries. (Exhibit 1, page 10; Exhibit A)

3. On [redacted], the Appellant signed an Adult Services Application, in part indicating that she lived alone. The application also listed the Appellant's responsibilities, including reporting changes in her situation within 10 days. (Exhibit 2)

4. The Appellant was initially authorized for HHS was a total monthly care cost of $[redacted]. The monthly care cost was increased to $[redacted] effective [redacted], and $[redacted] effective [redacted]. (Exhibit 1, page 14)

5. The $[redacted] per month included HHS hours for assistance with bathing, grooming, dressing, transferring, mobility, housework, laundry, shopping, and meal preparation. (Exhibit 1, page 13)

6. [redacted] was enrolled as the Appellant's HHS provider. (Exhibit 1, apogees 13-14)

7. On or about [redacted], [redacted], an elderly woman, moved into the Appellant's home. The Appellant was given money monthly from [redacted] daughter, which was used to provide care for [redacted]. (Appellant Testimony)

8. The Appellant did not report to the Department that [redacted] had moved into her home. (Appellant Testimony)

9. On [redacted], the ASW received an Adult Protective Services ("APS") referral from the [redacted] County Sheriff's Department and Mercy Memorial Hospital regarding [redacted] with the Appellant as the suspect. (Exhibit 1, page 8)

10. The ASW received information from the [redacted] County Sheriff's Department, [redacted] Hospital, and [redacted] daughter. In part, the information provided to the ASW indicated that the Appellant was being paid to provide care for [redacted]. (Exhibit 1, page 8, ASW Testimony)

11. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating her HHS case would be suspended effective [redacted] and had been submitted to the Office of Inspector General for investigation of fraud. (Exhibit 1, pages 4-6)

12. The Appellant signed a Request for Hearing on [redacted]. (Circuit Court Record, Exhibit 10)

13. On [redacted], the State Office of Administrative Hearings and Rules[1] sent the Appellant a letter indicating the Appellant's hearing request was received on [redacted], but from the information submitted it could not be determined why a hearing was requested. (Circuit Court Record Exhibit 9)

14. On [redacted], the Appellant submitted a revised request for hearing. (Circuit Court Record Exhibit 8)

15. On [redacted] the Appellant's HHS case closed because the ASW had not heard back from the Appellant. (ASW Testimony)

16. On [redacted], a hearing was held and on [redacted] a Decision and Order was issued by ALJ [redacted]. (Circuit Court Record Exhibit 4)

17. On [redacted], the Honorable [redacted], [redacted] Judicial Circuit Court, [redacted] County issued an Order to Remand for Rehearing. (Order to Remand for Rehearing)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

Adult Services Manual (ASM 363, 9-1-08), addresses the comprehensive assessment, functional assessment, time and task authorization, service plan development, necessity for services, and services not covered:

> **COMPREHENSIVE ASSESSMENT**
>
> The Adult Services Comprehensive Assessment (FIA-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not.

[1] In April 2011, the State Office of Administrative Hearings and Rules changed to the Michigan Administrative Hearing System.

ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

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

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

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 client's ability to perform the following activities:

Activities of Daily Living (ADL)

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

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping
- Laundry
- Light Housework

Functional Scale 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 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:

- 5 hours/month for shopping

- 6 hours/month for light housework
- 7 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.

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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 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-54-A.

- 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 same time period).

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Necessity For Service

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

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client 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.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services.

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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;
- Home delivered meals;
- Adult day care.

Adult Services Manual (ASM) 363, 9-1-2008,
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The Appellant was initially authorized for HHS of a total monthly care cost of $[redacted]. The monthly care cost was increased to $[redacted] effective [redacted], and $[redacted] effective [redacted]. The $[redacted] per month included HHS hours for assistance with bathing, grooming, dressing, transferring, mobility, housework, laundry, shopping, and meal preparation. (Exhibit 1, apogees 13-14) The above cited Department policy indicates that the HHS hours for housework, shopping, laundry, and meal preparation are to be prorated in shared household. Accordingly, an accurate reporting of the household composition is needed to determine the appropriate HHS authorization.

On [redacted], the Appellant signed an Adult Services Application, in part indicating that she lived alone. The application also listed the Appellant's

responsibilities, including reporting changes in her situation within 10 days. (Exhibit 2) On or about [redacted], [redacted], moved into the Appellant's home. The Appellant did not report to the Department that [redacted] had moved into her home. (Appellant Testimony)

The Appellant testified that she did not recall any duty to report changes, did not believe it was relevant to report that [redacted] had moved into her home and it was not her intent to defraud or deceive the Department. The Appellant asserted that she did not profit from the funds she received to arrange for the care of [redacted] and that [redacted] moving in did not change the her own needs for assistance. (Appellant Testimony)

However, the issue is not whether or not the Appellant profited from the funds she received each month to arrange for the care of [redacted]. The Appellant had a duty to report any changes in her household composition. Section B of the Adult Services Application is titled "Current Situation" and item 2 of this section is where the Appellant marked "Alone" for her "Living Arrangement." (Exhibit 2, page 1) The second page, just above the Appellant's signature states:

> 2. **You have the following responsibilities:**
>
> - To give full and correct information about your situation. Information you give may need to be verified.
>
> - To report within 10 days to the Department of Human Services if your situation changes.
>
> 3. Read the following statement, sign and date the application.
>
> - I WISH TO APPLY FOR SOCIAL SERVICES. I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS CORRECT. I AGREE TO FULFILL THE RESPONSIBILITIES DESCRIBED IN THE RIGHTS, RESPONSIBILITIES AND INFORMATION SECTION ABOVE. IF YOU WISH FINANCIAL OR MEDICAL ASSISTANCE, ANOTHER APPLICAION IS NEEDED.
>
> (Exhibit 2, page 2)

The Appellant failed to inform the Department that her household composition changed in [redacted]. The ASW properly suspended the Appellant's HHS case and made a referral for fraud based on the failure to report this change because household composition is considered in determining the appropriate hours for activities the Appellant had been authorized HHS for, specifically housework, shopping, laundry and meal preparation.

Additional concerns regarding fraud were raised by the information the ASW received from the [redacted] County Sheriff's Department, [redacted] Hospital, and [redacted] daughter. In part, the information provided to the ASW indicated that the Appellant was being paid to provide care for [redacted]. (Exhibit 1, page 8, ASW Testimony) If the Appellant was able to provide care to [redacted], this would imply she did not need assistance with her own ADLs and IADLs. This also supports the ASW's determination to suspend the Appellant's HHS case and make the referral for fraud.

The Appellant clearly contests any allegation that she was providing care to [redacted] herself, that she did not continue to require HHS for herself, or that she intended commit fraud regarding her HHS case. However, determinations on these issues are outside the scope of this hearing. The ASW referred the Appellant's HHS case to the Office of Inspector General for the fraud investigation. This hearing is limited to reviewing the Department's determination to suspend the Appellant's HHS case. A suspension of an HHS case is appropriate where there is a suspicion of fraud. The information available to the ASW in [redacted] was sufficient to suspend the Appellant's HHS case for possible fraud.

However, the Department failed to give the required advance notice of the suspension. Adult Services Manual policy addresses when the Advance Negative Action Notice form is to be issued:

> **Advance Negative Action Notice (DHS-1212)**
>
> If independent living services are denied or withdrawn, or if payment is suspended or reduced, the adult services worker must notify the client of the negative action.
>
> The Advance Negative Action Notice (DHS-1212) is used and automatically generated on ASCAP when the following reasons are selected:
>
> • Reduced - decrease in payment.
> • Suspended - payments stopped but case remains open.
> • Terminated - case closure.
>
> *Adult Services Manual (ASM) 362, 12-1-2007,*
> Pages 3 of 5

The Code of Federal Regulations, Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

§ 431.211 Advance notice.

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

§ 431.213 Exceptions from advance notice.

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

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

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
(b) The facts have been verified, if possible, through secondary sources.

The Department erred by issuing the [redacted] Advance Negative Action Notice with a retroactive effective date, [redacted]. In cases where fraud is suspected, advance notice is still required, though the period of advance notice may be shortened to five days. The Payment Authorization History indicates the Department has already corrected the effective date to [redacted]. (Exhibit 1, page 14)

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly suspended the Appellant's HHS authorization but failed to provide the required advance notice of the negative action.

IT IS THEREFORE ORDERED THAT:

The Department's decision is PARTIALLY AFFIRMED and PARTIALLY REVERSED. The suspension of the Appellant's HHS case is upheld but can not be made effective any earlier than five days from the [redacted] Advance Negative Action. No further action is ordered because the Department has already corrected the effective date to [redacted].

\s
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/13/2012

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.