STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 14-014619

[redacted]

Appellant.
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 C.F.R. § 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Worker from the [redacted] County DHS Office, appeared as a witness for the Department. Sarah Davis, Adult Services Supervisor was also present but did not testify.

ISSUE

Did the Department act properly in suspending or delaying payments for Appellant's Home Help Services (HHS) until a new provider was enrolled?

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 (DOB [redacted]) Medicaid beneficiary. (Exhibit A, p. 8 and testimony).

2. Appellant has been receiving Adult Home Help Services (HHS) for about [redacted] years. (Testimony).

3. On [redacted] Appellant called the ASW to advise that her provider had quit. (Exhibit A, p. 14 and testimony).

4. On [redacted], the ASW sent Appellant an Advance Negative Action Notice informing her that her HHS would be suspended effective [redacted], because she had no provider and that she had [redacted] business days to get a new provider or her payments would be suspended. (Exhibit A, pp. 2, 7, 11-13 and testimony).

5. On [redacted], MAHS received Appellant's Request for Hearing. (Exhibit A, pp. 4-7)

6. On [redacted] the Appellant and her new provider appeared at the DHS office and Appellant's new provider was enrolled. (Testimony).

CONCLUSIONS OF LAW

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

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

Adult Services Manual 135 (12-1-2013) (hereinafter "ASM 135") addresses policies relating to Home Help Providers, including the enrollment of such providers. ASM 135 states in part:

> **PROVIDER ENROLLMENT**
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> All home help providers **must** be enrolled in Bridges by a designee at the local county DHS office prior to authorizing payment. Once a provider is enrolled, Bridges will assign the provider a seven digit identification number. The adult services specialist must allow 24 hours from the time of enrollment for Bridges to interface with ASCAP. [ASM 135 p. 4 of 9, emphasis added].
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> * * *
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> **HOME HELP STATEMENT OF EMPLOYMENT (MSA-4676)**
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> The purpose of the MSA-4676, Home Help Services Statement of Employment, is to serve as an agreement between the client and provider which summarizes the general requirements of employment. The form is completed by the adult services specialist as part of the provider enrollment process.
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> An employment statement must be signed by **each** provider who renders service to a client. [ASM 135 p. 5 of 9, emphasis added].
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> * * *

> **MEDICAL ASSISTANCE HOME HELP PROVIDER AGREEMENT (MSA-4678)**
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> Federal regulations require that all providers of Medicaid covered services complete and sign a provider agreement. This agreement states providers will abide by Medicaid policies in providing services to program clients and in receiving payment from the program. In order to meet this requirement, the Michigan Department of Community Health (MDCH) developed the MSA-4678, Medical Assistance Home Help Provider Agreement.
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> **All** home help services providers must have a completed and signed MSA-4678 on file with the MDCH in order to receive payment. Providers are required to complete and sign the agreement only **once.** The signed agreement is valid for all counties across the state of Michigan. Home help agencies must complete this agreement in addition to meeting all other agency requirements. The MSA-4678 must be signed by the owner of the agency; see ASM 136, Agency Providers.
>
> ***Procedure***
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> The adult services specialist will furnish a copy of the MSA-4678 with instructions to all new individual and agency providers at the time of enrollment. [ASM 135 p. 6-7 of 9, emphasis added].

Adult Services Manual 140 (5-1-2013) (hereinafter "ASM 140") addresses when payment can be made for Home Help Services. ASM 140 states in part:

> **ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)**
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> The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. The adult services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.
>
> No payment can be made unless the provider has been enrolled in Bridges. Adult foster care, homes for the aged and home help agency providers must also be registered with Vendor Registration; see ASM 136, Agency Providers. [ASM 140, p. 1 of 4, 5-1-2013, emphasis added].

Adult Services Manual 170 (5-1-2013) (hereinafter "ASM 170") deals with case closure and termination or suspension of HHS payments. It states in part:

> **CASE CLOSURE PROCEDURES**
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> There are specific actions that must occur when closing an adult services case.

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

Termination of Home Help Payments

Home help services payments may be terminated and closing procedures initiated, in any of the following circumstances:

- The client fails to meet any of the eligibility requirements.
    - Medicaid eligible.
    - Medical professional does not certify a need for services on the DHS-54A, Medical Needs form.
    - Assessment determines client no longer requires home help services.
- The client no longer wishes to receive home help services.
- The client is receiving services from another program and this would result in a duplication of services.

Suspension of Home Help Payments

The adult services specialist may choose to suspend payments, rather than terminate payments and initiate closing procedures, in the following circumstances:

- Client's Medicaid has ended and it appears to be temporary.
- Client's provider fails to meet qualification criteria. This allows the client time to locate a new provider.
- Provider logs were not submitted timely but it is believed the client and provider will return completed forms within a specified time period noted on a negative action notice.

Note: Any suspended payment action must be temporary. The adult services specialist should allow no more than 90 days for the situation to be resolved. (The DHS-390, Adult Services Application and the DHS-54A, Medical Needs form, are valid for 90 days after case closure). Case closure procedures should be initiated once it has been determined the situation that resulted in the suspension will not be resolved. [ASM 170, pp. 1-2 of 3, 5-1-2013, emphasis added].

In this case the Appellant's ASW, [redacted], stated the Appellant called her on [redacted] to report that her provider quit. The ASW stated on [redacted] she sent the Appellant an Advance Negative Action Notice informing her that her HHS payments would be suspended effective [redacted], because Appellant had no provider. The ASW stated on [redacted] the Appellant and her new provider came to the DHS office on [redacted] and the Appellant's new provider was enrolled so he could start providing services and receive payment for those services under the HHS program. The ASW stated [redacted] was the last date for which the Appellant's previous provider received payment. (See Exhibit A, p. 19). It was also noted that the first date the Appellant's new provider received payment for was [redacted]. (See Exhibit A, p. 19). Finally, the ASW acknowledged that Appellant's previous provider, who quit, was not paid for the services she provided for the months of [redacted] through [redacted] until after she quit. Payment for those months was issued on [redacted]. (See Exhibit B).

During the hearing, Appellant raised a question as to a missed payment from [redacted]. Appellant was advised that more than [redacted] days had past and that the undersigned had no jurisdiction to consider the matter as this would be considered a late appeal. See 42 CFR 438.400 which requires that the Appellant file a request for hearing within [redacted] days of the date the Department sent notice of denial, reduction, termination, or suspension of a Medicaid covered service. Appellant also urged that it was the fault of DHS that her provider quit because she was not being paid, and that she had to pay out of her own pocket for services provided by her new provider between [redacted] and [redacted]. Appellant said the issue on appeal was that she was seeking reimbursement for money she paid in the interim. She said her case was not closed and she was receiving services by her new provider, although he had not yet been enrolled by DHS. When questioned by the Department's representative, she acknowledged that she had been in the HHS program for [redacted] years. She reluctantly acknowledged that she knew that her new provider had to be enrolled before DHS could authorize payment for services.

The preponderance of the reliable evidence presented in this case demonstrates that it DHS acted properly by suspending or delaying the Appellant's HHS payments until she got a new provider. Furthermore, neither party provided an explanation for the delayed payments to prior provider who quit, but in any event the provider was paid for her services. The policy quoted above makers it clear that payments cannot be made until there is an enrolled provider, and a person cannot begin performing services under the HHS program until they complete and sign a provider agreement which is a part of the enrollment process. Furthermore, it is entirely permissible for DHS to suspend payments instead of terminating services where it is likely a new provider will be enrolled soon and the situation appears to be only a temporary one. This allows the Appellant time to locate a new provider. Accordingly, the Department properly suspended, or if you will, delayed further HHS payments for the Appellant until her new provider was enrolled. The Department's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department acted properly in suspending or delaying further payments for the Appellant's HHS until the new provider was enrolled.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/db

cc: [redacted]

***** NOTICE *****

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