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. 15-013655 HHS
Case No. [redacted]

Appellant.
_____/

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, a telephone hearing was held on [redacted]. Appellant appeared at the hearing to testify. [redacted], Appeals Review Officer, represented the Michigan Department of Health and Human Services (MDHHS or the Department or Respondent). [redacted], Social Worker, appeared as a witness for the Department. The caseworker who took the negative action was not present or available to testify at the hearing.

State's Exhibit A, pages 1-39 was admitted as evidence.

ISSUE

Did the Department properly reduce Appellant's Home Help Services ("HHS")?

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 Medicaid beneficiary.

2. Appellant was approved for HHS benefits for [redacted], [redacted], and [redacted].

3. Appellant's provider was paid for HHS performed in [redacted], [redacted] and [redacted].

4. Appellant has had several caseworkers from [redacted] forward.

5. Appellant is legally blind. He has diagnoses of hypertension, kidney disease/renal failure, diabetes, congestive heart failure and ESRD. Appellant receives dialysis three times per week.

6. On [redacted], Appellant contacted the Department and requested that his HHS case be cancelled because his HHS provider quit.

7. Appellant's HHS payments were suspended from [redacted] forward.

8. The HHS case did not close because the Department was involved in a recoupment action with Appellant because he had been in the hospital for a time period ([redacted] to [redacted]).

9. The recoupment action has been completed.

10. The HHS case remained opened despite the fact that Appellant requested cancellation in [redacted]

11. On [redacted], an Independent Living Specialist conducted a six month review with Appellant. (State's Exhibit A page 8)

12. In [redacted], Appellant requested reinstatement of his HHS services with a new provider.

13. On [redacted], the Department sent Appellant an Advance Negative Action Notice stating that Appellant's HHS would be suspended effective [redacted], because Appellant failed to submit provider logs for [redacted], [redacted] and [redacted].

14. On [redacted], the Michigan Administrative Hearing System received a request for hearing to contest the department's negative action, stating that Appellant turned in the logs to his previous worker for [redacted] to [redacted] and [redacted]. (State's Exhibit A page 4).

15. On [redacted], an in-home assessment was completed with Appellant and his new provider.

16. HHS payments were authorized in ASCAP beginning [redacted] through [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 Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.

Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.

Home help services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care facility (ICF) for persons with developmental disabilities or institution for mental illness.

These activities **must** be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. **The medical professional does not prescribe or authorize personal care services.** Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

Adult Services Manual (ASM) 120

- Each individual provider must keep a log of home help services delivered. The DHS- 721 is used for this purpose.
- Tasks on the provider logs are automatically marked with an X when printed from ASCAP based on the client's home help functional assessment.
- The provider must indicate what services were provided and on which days of the month.
- The client 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 quarterly. Provider logs must be received within 10 business days after the last service date on the log. Failure to do so will result in suspension of payment.
- The adult services specialist must initial and date the log upon receipt, demonstrating review of the log.
- Retain the log in the client's case record.
- A separate log is required for each provider.

- Incomplete logs must be returned to the client/provider for completion.

  Agency/business providers have the option of submitting monthly invoices in lieu of the DHS-721, Provider Log. Each invoice **must** specify the following:

  - The service (s) provided, and
  - The date(s) of service.

  See ASM 136, Agency Providers.
  ASM 135, pages 4-5

Department policy dictates that the provider **must** keep a log of the services provided on the DHS-721, Personal Care Services Provider Log and submit it on a quarterly basis. The log must be signed by both the provider and client or the client's representative to verify that the services approved for payment were delivered. A separate log is required for each provider. The log must be received within 10 business days after the last service date on the log. Failure to do so will result in suspension of payment.

The adult services specialist must initial and date the log upon receipt to demonstrate review of the log. The log is required to be retained in the client's case record. Incomplete logs must be returned to the client/provider for completion.

Agency/business providers have the option of submitting invoices instead of the DHS-721, Provider Log. Each invoice **must** specify the following:

- The service(s) provided, and
- The date(s) of service.

ASM 135

Appellant testified that he and his provider sent in logs when they received them in the email and sometimes went into the Department office to provide the completed provider logs. He does not know what the caseworkers did with the information. He and his provider always provided the completed provider logs. When the new caseworker came to him she told him that he must sign the back dated provider logs or his HHS would be cancelled. His provider was not available because he was working. Appellant testified that he did receive HHS services in [redacted], [redacted] and [redacted], but cannot sign an affidavit or logs that may or may not be accurate at this late date, because the Department might find the old logs that he sent in and then charge him with fraud. He also refused to sign the documents because he is legally blind, cannot read the documents, cannot accurately recreate documents that he turned in in [redacted], [redacted], and [redacted]; and he does not trust the Department representative.

Appellant's HHS case was fine until [redacted], when the new caseworker came to him and requested that he sign provider logs for [redacted], [redacted] and [redacted]. He alleges that he or his provider mailed the logs in to the Department when they were due as is required by policy and that no payments were missed in [redacted], [redacted], or [redacted]. This Administrative Law Judge determines that Appellant's testimony is credible and finds the evidence shows that the Department did pay Appellant's (several different) providers for HHS services rendered during the relevant times. State's Exhibit A pages 23-28.

The evidence on the record indicates that the Department paid the providers for services in [redacted], [redacted] and [redacted] as is appropriate if the services were actually performed as approved. The witnesses for the Department were not the caseworkers who were working on the Appellant's HHS case in [redacted], [redacted], or [redacted]. None of the former caseworkers who actually worked on the file were present at the hearing to testify as to the condition of the file when they had it. No one who actually worked on the file in [redacted], [redacted] or [redacted] was available at the hearing to testify as to whether or not the logs were in the file at some point and subsequently disappeared. Thus, the Department cannot establish with any credibility that the Appellant's case file never contained the logs. The Department cannot require Appellant to sign documents against his will and cannot require Appellant to assist the Department in recreating documents so that the case files can be complete for audit purposes.

Based on the evidence as presented, the Department has not established by the necessary competent, substantial and material evidence on the record that it was acting in accordance with Department policy when it issued an Advance Negative Action Notice to Appellant, informing Appellant that no further HHS payments can be authorized until past due provider logs are returned. The Department cannot recoup HHS benefits under these circumstances as the Department has not established that the provider logs were never turned in. The Department has not established that an overpayment of HHS has occurred. Testimony that ASCAP does not contain a record of the logs is not sufficient to establish that the logs were never turned in to the Department. ASCAP is a computer system that the caseworkers make notes in. If the appropriate provider logs were received and are not manually entered into ASCAP, it follows that the information would not be available on the computer record three years later. If the different adult services specialists authorized payment for services performed in [redacted], [redacted] and [redacted] without receipt of provider logs for services performed, it is an administrative error and no recoupment is established or necessary. ASM 165, page 3.

ASM 165 states explicitly that the Department is responsible for correctly determining accurate payment for services. The only thing that the Department has established in this case is that the Department case file does not currently contain the provider logs from [redacted], [redacted] or [redacted]. The Department's determination 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 has not established by a preponderance of the evidence that Appellant failed to provide provider logs.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **REVERSED**. The Department is **ORDERED** to rescind any potential negative action for failure to return logs; and ensure that there has been no suspension of HHS payments. If there has been suspension of payments, the Department is **ORDERED** to pay to Appellant's current provider any HHS payments to which Appellant has been determined eligible for from [redacted] forward.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

LYL[redacted]

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.