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

IN THE MATTER OF:

Docket No. 2010-28777 HHS
Case No. [redacted]

[redacted],

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], mother and Guardian, appeared on the Appellant's behalf. [redacted], step-father, appeared as a witness for the Appellant. [redacted] was also present. [redacted], Appeals and Review Officer, represented the Department. [redacted], Adult Services Worker, and [redacted], Adult Service Supervisor, appeared as witnesses for the Department.

ISSUE

Did the Department properly suspend 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 [redacted] Medicaid beneficiary who has been diagnosed with cervical palsy, seizure disorder, and chronic encephalopathy. (Exhibit 1, page 11)

2. The Appellant's mother is her chore provider for the Home Help Services program. (Exhibit 1, pages 8-10)

3. The Appellant also receives Community Living Supports services through Community Mental Health. (Exhibit 1, pages 9-10, and Exhibit 2)

4. On [redacted], the Department issued an Advance Negative Action Notice to the Appellant indicating that her Home Help Services case would suspended effective [redacted]0, because she was receiving the personal care payments from two agencies. The Department immediately suspended HHS payments to the Appellant, including payment for the hours worked prior to the [redacted] notice. (Testimony and Exhibit 1, pages 3-6)

5. On [redacted], the State Office of Administrative Hearings and Rules received the Request for Hearing signed by the Appellant's Guardian. (Exhibit 1, page 3)

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.

Adult Services Manual (ASM 362) 12-1-2007, page 4 of 5 addresses the issue of termination and suspension of HHS payments:

> **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.

Additionally, 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)

The [redacted], [redacted] Advance Negative Action Notice issued by the Department clearly failed to provide the Appellant with the required advance notice of at least ten (10) days for the suspension of her HHS case. The effective date of the termination is the same date the notice was issued, [redacted]. (Exhibit 1, page 4) None of the exceptions to the advance notice requirement were present in this case. The Department failed to give the Appellant any advance notice of the negative case action, and in so doing failed provide a negative action period during which the Appellant could file a hearing request and allow the payments to continue until the issuance of a hearing decision.

Even more troubling was the Department's decision to immediately stop payment on the Appellant's case, not just suspend ongoing services effective [redacted]. The Appellant has not received payment for HHS hours provided prior to the [redacted], notice. The Adult Services Worker testified she did this to prevent issuing a payment that would have to be recouped. Department policy does not support what was in effect a retroactive suspension of the Appellant's HHS payments. Payment should have been issued for services provided to the Appellant prior to the [redacted], Advance Negative Action Notice.

Further, the Department proceeded with this suspension without determining ongoing Home Help Services eligibility by completing a comprehensive assessment and service plan review. Adult Services Manual (ASM 363) 9-1-2008, pages 2-11 of 24 addresses the issues of the comprehensive assessment, service plan and coordination with other services:

> **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. 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.

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. Adult Services Manual (ASM 363) 9-1-2008, pages 4-5 of 24 addresses the issue of service plan development:

***

SERVICE PLAN

A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment.

The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy

Service planning is person-centered and strength-based.

Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the caregiver, if applicable.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services, and
- Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

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-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 same time period).

***

COORDINATION OF HHS WITH OTHER SERVICES

Coordinate available home care services with HHS in developing a services plan to address the full range of client needs.

Do not authorize HHS if another resource is providing the same service at the same time.

In the present case, the Department immediately suspended the Appellant's HHS case upon learning that she was receiving other personal care services through Community Mental Health. The Department failed to first gather information regarding these other services to determine if there was a duplication of services. Department policy requires the comprehensive assessment and service plan review at least every six (6) months, or more often if necessary. When the Department learned that the Appellant was receiving services from another resource, this should have triggered a comprehensive assessment and service plan review. The Department must gather information regarding what specific services are being provided by each source prior to making any reductions, suspension, or termination of the Appellant's HHS case for a services duplication. Under the Department policy, the worker should consider all services provided to the Appellant when reviewing the service plan in an effort to coordinate the available home care services and ensure that the Appellant's full range of needs is addressed.

At the hearing, the Appellant's mother provided a copy of the Appellant's Person Centered Plan from Community Mental Health. According to this plan, the Appellant does receive Community Living Supports (CLS) services. The CLS services include assistance with personal care activities such as transferring, mobility, eating, toileting, bathing, dressing, grooming, and medications as well as assistance with daily participation in household chores. (Exhibit 2, page 8) The Appellant's HHS hours also included these activities as well as other tasks. (Exhibit 1, page 8) However, the Medicaid Policy Manual does allow a beneficiary to receive both CLS services and HHS services:

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:

- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS **assistance** with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Medicaid Provider Manual,
Mental Health/ Substance Abuse Section,
April 1, 2010, Pages 100-101[1]

The Appellant's step father credibly testified that when the Appellant first began receiving CLS services, Community Mental Health sent them to the Department of Human Services to apply for the HHS program and that the Appellant could receive services under both programs, so long as the same service was not being provided by each program at the same time. This is consistent with the above cited Medicaid policy. The Appellant's stepfather also stated that when the Appellant began receiving services, both programs knew the Appellant was receiving services the other agency, however, the assigned workers have changed for both programs.

Under the above cited Medicaid policy, CLS assistance may be authorized to provide reminding, guiding, and/or training for activities without supplanting services provided under the HHS program. Further, this policy does allow Community Mental Health to make a determination that the Appellant has needs in excess of the HHS and authorize CLS services to complement the HHS program services.

[1] See also Medicaid Provider Manual, Mental Health/Substance Abuse Section, April 1, 2010, Pages 81-82 for CLS provided through the Habilitation and Supports Waiver.

The Department's action to immediately suspend HHS payments in the Appellant's case appears to be based on an incorrect belief that policy does not allow the Appellant to receive services from multiple resources during the same time period. This is not correct. The Department's policy specifically allows a beneficiary to receive services from multiple resources so long as they are not duplicative. The Department failed to obtain any information on the other services the Appellant received prior to implementing a suspension of her HHS payments with no advance notice. The Department made no attempt to coordinate the services available to the Appellant. Further, the Medicaid Provider Manual specifies that CLS services do not supplant, and can even be used to complement, services received under the HHS program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department did not properly suspend Home Help Services payments to the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department shall reinstate the Appellant's Home Help Services payments retroactive to the [redacted], termination date. The Department shall also ensure that payments are made for the HHS hours worked prior to the [redacted] Advance Negative Action Notice.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: **6/25/2010**

***** 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.