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:

[redacted]

Appellant
_____/

Docket No. 2010-9741 HHS
[redacted]

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], attorney, appeared on the Appellant's behalf. [redacted], mother and Guardian, appeared as a witness for the Appellant. [redacted] and [redacted], were also present but did not testify. [redacted], Appeals and Review Officer, represented the Department. [redacted], Adult Services Specialist, and [redacted], Adult Services Supervisor, were present as Department witnesses.

ISSUE

Did the Department properly terminate Home Help Services 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 was receiving Adult Home Help Services.

2. The Appellant has been diagnosed with Canavan disease and seizure disorder. (Exhibit 1, page 9)

3. The Appellant's mother is his chore provider. (Exhibit 1, page 10)

4. Effective [redacted], the Appellant was enrolled in [redacted], the [redacted]. (Exhibit 1, pages 12 and 18)

5. This change in the Appellant's level of care code was processed by the Department of Human Services on [redacted] and notice of the Appellant's enrollment in the waiver program was provided to the Adult Services Supervisor on [redacted]. (Testimony)

6. The Department did not investigate what services the Appellant receives through the [redacted] waiver program. (Testimony)

7. On [redacted], the Department issued an Advance Negative Action Notice to the Appellant indicating that his Home Help Services payments would terminate effective [redacted], due to his enrollment in the waiver program. (Exhibit 1, pages 5-8)

8. A faxed request for a formal, administrative hearing was received by the State Office of Administrative Hearings and Rules for the Michigan Department of Community Health on [redacted], signed by the Appellant's mother. On [redacted], the request was re-submitted by fax, with a hard copy received by mail on [redacted], with the Appellant's mark and re-signed by the Appellant's mother with a notation that she is the Appellant's Guardian.

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 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] DHS 1212 Advance Negative Action Notice issued by the Department clearly failed to provide the Appellant with the required advance notice of at least 10 days that his HHS payments would terminate as the effective date of the termination was also [redacted]. (Exhibit 1, page 5) 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.

Further, the Department proceeded with this termination without completing a comprehensive assessment to determine ongoing Home Help Services eligibility. Adult Services Manual (ASM 363) 9-1-2008, pages 2-11 of 24 addresses the issue of the comprehensive 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.

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.

Adult Services Manual (ASM 363) 9-1-2008, Pages 2-11 of 24

Effective [redacted], the Appellant was enrolled in [redacted], the [redacted] for the Elderly and Disabled. (Exhibit 1, pages 12 and 18) The Appellant has presented some evidence that notice of the waiver enrollment was delivered to the Department of Human Services on [redacted], although it is noted that the delivery address is not listed on either the UPS delivery confirmation or tracking print outs. (Exhibit 2, pages 1-4) The Department of Human Services did receive the faxed notice of the Appellant's enrollment in the waiver program sent on [redacted]. (Exhibit 1, page 12) The Adult Services Specialist testified that the Department of Human Services Medicaid eligibility worker processed this change in the Appellant's level of care code on [redacted] and forwarded notice of the Appellant's enrollment in the waiver program to the Adult Services Supervisor on [redacted].

The Adult Services Specialist and the Adult Services Supervisor testified that the Department policy does not allow eligibility for Adult Services programs, such as Home Help Services, when a client is enrolled in the [redacted] program. Therefore, the Appellant's Home Help Services case was immediately terminated without completion of the scheduled home visit. (Exhibit 1, pages 4-8) While a copy of this policy was not submitted at the hearing, the Adult Services Specialist testified if can be found in Adult Services Manual (ASM) 363.

This ALJ has reviewed ASM 363 and found no prohibition to eligibility for Home Help Services for a client enrolled in the [redacted] program. To the contrary, ASM 363 anticipates the possibility of services being provided by other resources and has a provision for coordination of Home Help Services with other services. *Adult Services Manual* (ASM 363) 9-1-2008, page 11 of 24. The Department policy only prohibits a duplication of services. *Adult Services Manual* (ASM 363) 9-1-2008, pages 5 and 11 of 24. Therefore, when a Home Help Service client is also receiving services from another resource, the Department should perform a comprehensive assessment and develop a service plan determining an appropriate authorization of HHS hours, which does not allow for a duplication of services.

In the present case, the Adult Services Specialist and Adult Services Supervisor testified that they did not investigate what services the Appellant is receiving through the

[redacted]. The Appellant's mother testified that the only waiver benefit the Appellant receives is payment toward the Appellant's [redacted] insurance premium. The Appellant's mother explained that the insurance company is then required to provide the Appellant with skilled nursing care 12 hours per day. However, this ALJ notes that payment of an insurance premium is not a service covered by the [redacted]. (Exhibit 1, page 15)

Even if the Appellant does not receive nursing services through the [redacted] program, the Department must still consider all services provided to the Appellant, regardless of the source, when completing the comprehensive assessment and developing the service plan. Based upon the testimony at the hearing, there may be some duplication of services between the 12 hours of nursing services the Appellant receives and the previously authorized Home Help Services time and task hours. A comprehensive assessment is necessary to determine the Appellant's ongoing eligibility for Home Help Services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department did not properly terminate home help assistance payments for the Appellant. The Department failed to give the required advance notice of the negative case action, the basis for the termination is not supported by Department policy, and no comprehensive assessment was completed.

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 December 7, 2009 termination date. The Department shall complete a comprehensive assessment to determine the Appellant's ongoing eligibility for Home Help Services and provide advance notice to the Appellant of any changes to the authorized payment.

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

cc: [redacted]

[redacted]
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Decision and Order

[redacted]

Date Mailed: 3/2/2010

***** 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.