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. 2011-46618 HHS
Case No. [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], the Appellant, appeared on her own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Service Worker (ASW), and [redacted], Acting Supervisor, appeared as witnesses for the Department.

ISSUE

Did the Department properly propose a suspension of the Appellant's Home Help Services (HHS) case?

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] year old Medicaid beneficiary.

2. On [redacted], the Appellant called the Department to re-schedule the home visit appointment because she had to go to dialysis that day. (Exhibit 1, page 12)

3. On [redacted], the ASW left a message returning the Appellant's call. (Exhibit 1, page 12)

4. On [redacted], the ASW spoke with the Appellant discussing when a home visit appointment could be scheduled. (Exhibit 1, page 11)

5. On [redacted], the ASW attempted to complete a home visit, but the Appellant was unable to complete the interview because her cat died. The

Appellant reported she would to go to the Department office with her provider on Monday. (Exhibit 1, page 11)

6. On [redacted], the Appellant called the ASW explaining that she has not been able to do anything since her cat's sudden death and requested the ASW return to complete the home visit on Friday. (Exhibit 1, page 10)

7. On [redacted], the Department issued an Advance Negative Action Notice to the Appellant indicating her HHS case was suspended effective [redacted], because the redetermination home visit had not been completed. The notice also indicated a home visit was scheduled for [redacted]. (Exhibit 1, pages 5-8)

8. On [redacted], the Appellant called the ASW to reschedule and it was explained that the appointment had already been rescheduled for [redacted]. (Exhibit 1, page 10)

9. On [redacted], the Appellant called the ASW reporting that her lights were out and requesting the home visit appointment be rescheduled, but agreed to the ASW coming as the last appointment of the day. The ASW went to the Appellant's home that afternoon and left her card in the door as there was no answer to knocks on the door and no car in the driveway. (Exhibit 1, page 10)

10. On [redacted], the Appellant filed a hearing request contesting the suspension. (Exhibit 1, page 4)

11. On [redacted], the Appellant left a message wanting to come into the office. (Exhibit 1, page 9)

12. On [redacted], the Appellant called the ASW asking about changing HHS providers and a new home visit appointment. The Appellant called back having changed her mind about the appointment and inquiring about when the hearing would be scheduled. (Exhibit 1, page 9)

13. The Department has since completed the home visit appointment and annual redetermination of the Appellant's HHS case. The Appellant's HHS payments have been authorized. (ASW 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 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, addresses the issue of contacts and reviews in HHS cases:

> **CONTACTS**
>
> The worker must, at a minimum, have a face to face interview with the client **and** care provider, prior to case opening, then every six months, in the client's home, at review and redetermination.
>
> ***
>
> **REVIEW**
>
> Update the comprehensive assessment and the service plan every six months. Review the adequacy of the service plan to assure it meets the client's current needs.
>
> Review eligibility for independent living services every 12 months, or sooner if the client's condition or circumstances warrant.
>
> The annual review requires:
> - MA eligibility verification, if relevant.
> - Comprehensive assessment.
> - Service plan.
> - Renewal of the medical needs (DHS-54A).
>
> **Note:** The medical needs form for **SSI** recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients must have a DHS-54A completed at the initial opening and then annually thereafter.
>
> Adult Services Manual (ASM 362) 12-1-2007,
> Page 3-4 of 5

Adult Services Manual (ASM 363) 9-1-2008, also addresses comprehensive assessments, service plans, and review requirements:

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-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.

***

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.

***

REVIEWS

ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review

Requirements

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

Documentation

Case documentation for all reviews should include:

- Update the **"Disposition"** module in ASCAP.
- Generate the CIMS Services Transaction (DHS-5S) from **forms** in **ASCAP**.
- Review of **all** ASCAP modules **and** update information as needed.
- Enter a brief statement of the nature of the contact and who was present in **Contact Details** module of ASCAP.
- Record expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- Record summary of progress in service plan by clicking on **Insert New Progress Statement in General Narrative** button, found in any of the **Service Plan** tabs.

Annual Redetermination

Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

Requirements

- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- A new medical needs (DHS-54A) certification, if home help services are being paid.

Note: The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.

- A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

Adult Services Manual (ASM 363) 9-1-2008,
Pages 2-7 of 24

The Adult Services Manual requires an annual redetermination review of HHS cases, including a face to face contact in the client's home. Department policy does not allow an ASW to continue HHS payments unless this has been competed. Multiple attempts

to complete the required home visit were documented in the ASW's general narrative notes. (Exhibit 1, pages 9-12)

The Appellant's hearing request states she had emergencies both times a home visit was scheduled and she has been hospitalized six times in the last three months. (Exhibit 1, page 4) The Appellant asserted that HHS cases should not be suspended because this interrupts care.

While this ALJ understands the Appellant's concerns with needing care on an ongoing basis, Department policy requires the annual redetermination for payments to continue. Accordingly, the Department properly proposed a suspension because the required home visit and redetermination could not be completed.

However, the Department failed to give advance notice of the suspension. The [redacted] Advance Negative Action Notice indicates that the Department intends to make the suspension of the Appellant's case effective that same date, [redacted]. (Exhibit 1, page 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 [redacted], Advance Negative Action Notice issued by the Department clearly failed to provide the Appellant with the required advance notice of at least 10 days as the effective date of the reduction was also [redacted]. (Exhibit 1, page 4) None of the exceptions to the advance notice requirement were present in this case. Therefore, the Department should not have implemented the suspension of the Appellant's HHS case any earlier than 10 days after the [redacted], Advance Negative Action Notice. However, it was uncontested that the Department has since completed the home visit and authorized the Appellant's HHS payments.

The Appellant contests the reduction and effective date of the reduction to her HHS payments that resulted from the redetermination. As discussed during the hearing proceedings, the suspension is a separate action from the reduction, which occurred after the Appellant's [redacted], hearing request was filed. If she has not already done so, the Appellant may wish to file a new hearing request contesting the reduction to her HHS case, including the effective date of the reduction, within 90 days of the notice issued for that action.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department properly proposed a suspension of the Appellant's Home Help Services case, but failed to give advance notice of at least 10 days.

IT IS THEREFORE ORDERED that:

The Department's decision is PARTIALLY AFFIRMED AND PARTIALLY REVERSED. However, there is no order as the Department has already authorized HHS payments to the Appellant.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/27/2011

***** 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.