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:

Docket No. 2012-21888 HHS

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 hearing was held on . The Appellant appeared without representation. His witness, , did not testify. , Appeals Review Officer, represented the Department. Her witnesses were ,

ISSUE

Did the Department properly terminate the 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. The Appellant is a disabled -year old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant alleges disability and the need for HHS owing to the afflictions of myocardial infarction (MI), COPD, HTN, gout, arthritis, Hepatitis C – at hearing he alleges severe dizziness. (*See* Testimony and Department's Exhibit A, page 9)

3. The Appellant said at the time of in-home assessment he had recently been hospitalized for a and that he was so dizzy he could not bend over to tie his shoes. (*See* Testimony and Appellant's Exhibit #1)

4. The Department's representative said she observed that the Appellant did not need assistance with any personal care service and that the Appellant verbalized that nothing had changed in terms of his service needs. (*See* Testimony and Department's Exhibit A, pages 2 and 6)

5. The Department witness testified further that she made contact with the Appellant on , for the in-home assessment. While there, she reviewed the personal care tasks of all ADLs individually – noting in her testimony that the Appellant did not request any assistance with personal care services. She also noted that at the time of the in-home assessment the Appellant was not receiving assistance with personal care. (*See* Testimony of Baldwin and Department's Exhibit A, pages 6, 8 and 11)

6. On redirect examination the ASW testified that the Appellant never told her about his dizziness or how that translated into a need for assistance with the of dressing.)

7. The Department witness sent the Appellant an Advance Negative Action notice on , terminating services effective . (Department's Exhibit A, pages 2, 5)

8. The Appellant's further appeal rights were contained in the Advance Negative Action Notice.

9. The request for hearing on the instant appeal was received by the Michigan Administrative Hearing System for the Department of Community Health on (Appellant's Exhibit #1)

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 medical professional.

> **COMPREHENSIVE ASSESSMENT**
>
> The DHS- ry tool for determining need for services. The comprehensive assessment must be completed on all open independent living services cases. ASCAP, the automated

workload management system, provides the format for the comprehensive assessment and all information must 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.
- The assessment may also include an interview with the individual who will be providing home help services.
- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- 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.

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Adult Service Manual (ASM), §120, page 1 of 6, 11-1-2011.

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Changes in the home help eligibility criteria:

Home Help Eligibility Criteria
To qualify for home help services, an individual must require assistance with at least one activity of daily living (ADL) assessed at a level 3 or greater. The change in policy must be applied to any new cases opened on or after October 1, 2011, and to all ongoing cases as of October 1, 2011.

Comprehensive Assessment Required Before Closure
Clients currently receiving home help services must be assessed at the next face-to-face contact in the client's home to determine continued eligibility. If the adult services specialist has a face-to-face contact in the client's home prior to the next scheduled review/redetermination, an assessment of need must take place at that time.

Example: A face-to-face review was completed in August 2011; the next scheduled review will be in February 2012. The specialist meets with the client in his/her home for a provider interview in December 2011. Previous assessments indicate the client only needing assistance with instrumental activities of daily living (IADL). A new comprehensive assessment must be completed on this client.

If the assessment determines a need for an ADL at level 3 or greater but these services are **not** paid for by the department, or the client refuses to receive assistance, the client would **continue** to be eligible to receive IADL services.

If the client is receiving only IADLs and does **not** require assistance with at least one ADL, the client no longer meets eligibility for home help services and the case must close after negative action notice is provided.

Each month, beginning with October, 2011, clients with reviews due who only receive IADL services must take priority.

Negative Action Notice
The adult services specialist must provide a DHS-1212, Advance Negative Action notice, if the assessment determines the client is no longer eligible to receive home help services. The effective date of the negative action is ten business days after the date the notice is mailed to the client.

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Right to Appeal
Clients have the right to request a hearing if they disagree with the assessment. If the client requests a hearing within ten business days, do not proceed with the negative action until after the result of the hearing.

> Explain to the client that if the department is upheld, recoupment must take place back to the negative action date if payments continue. Provide the client with an option of continuing payment or suspending payment until after the hearing decision is rendered.
>
> If the client requests a hearing after the 10-day notice and case closure has occurred, do not reopen the case pending the hearing decision. If the department's action is reversed, the case will need to be reopened and payment re-established back to the effective date of the negative action. If the department's action is upheld, no further action is required.

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Adult Service Bulletin (ASB) 2011-001;
Interim Policy Bulletin Independent Living Services (ILS)
Eligibility Criteria, pp. 1–3, October 1, 2011

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The Department witness testified that on in-home assessment she discovered the Appellant had no need for [redacted] assistance. She explained policy developments and advised the Appellant that he would be terminated from the Home Help Program for lack of need with hands on assistance. She also reported that the Appellant had no new needs for personal care services.

At hearing the Appellant testified that he did not understand "…why out of the blue" his HHS was terminated – when he "…was so dizzy that he could not bend over to tie his shoes."

It is the province of the ASW to determine eligibility for services; the ASM requires an in-home, comprehensive assessment of HHS recipients. Based on new policy an HHS recipient must utilize at least one (1) [redacted] requiring hands-on service at the three (3) ranking or higher in order to remain eligible for HHS.

The Appellant failed to preponderate his burden of proof that the Department erred in terminating his HHS, because at the time of assessment he demonstrated no need for assistance. He made no request for personal care [redacted] and never volunteered information about his dizzy condition.

The Appellant suggested in his testimony that the dizziness, following his [redacted], was a new, adverse, health condition existing as of the date of comprehensive assessment. If that is so - it is the Appellant's responsibility under HHS program requirements to inform

the ASW of any changes in condition which might affect his receipt of HHS or merit reassessment.

The Appellant was advised on the record that should he not prevail in this appeal that he has a 90-day window in which he might reapply for HHS benefits without the necessity of reopening his case.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly terminated the Appellant's HHS.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: _____3-27-12__________________

***** 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.