

**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:

Docket No. 2014-10884 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.*, and upon a request for a hearing filed on behalf of Appellant.

After due notice, a hearing was held on ██████████.

Attorney ██████████ appeared on Appellant's behalf. Appellant; ██████████ Appellant's mother, home help provider and co-legal guardian; ██████████ Appellant's father and co-legal guardian; ██████████, an aide; ██████████, Appellant's brother; ██████████, a registered nurse; and ██████████, paralegal; were also present or testified on Appellant's behalf.

██████████, Appeals Review Officer, represented the Department of Community Health. ██████████, Adult Services Worker (ASW); ██████████, Adult Services Supervisor; ██████████, registered nurse; ██████████, registered nurse and private duty nursing specialist; and ██████████, policy analyst; were also present or testified on the Department's behalf.

ISSUE

Did the Department properly reduce and suspend 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 ██████-year-old Medicaid beneficiary who has been diagnosed with cerebral palsy; spastic quadriplegia; developmental delay; central apnea; and hypoventilation. (Respondent's Exhibit A, page 17).
2. Appellant's parents are her legal guardians. (Respondent's Exhibit A, pages 14-15).

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3. Appellant was referred for HHS in [REDACTED] and has been receiving services since that time. (Respondent's Exhibit A, page 16).
4. Appellant's mother is her sole enrolled home help provider. (Testimony of [REDACTED]; Testimony of ASW [REDACTED]).
5. Appellant case was first reviewed by RN [REDACTED] for Expanded Home Help Services (EHHS) in [REDACTED] and Appellant was subsequently approved for [REDACTED] hours and [REDACTED] minutes of HHS per month, with a total monthly care cost of [REDACTED]. (Respondent's Exhibit A, pages 26, 30).
6. In [REDACTED] and [REDACTED] RN [REDACTED] again reviewed Appellant's services. (Respondent's Exhibit A, pages 22, 30)
7. Following that review, Appellant received an Advance Action Notice providing that her HHS would be reduced to [REDACTED] hours and [REDACTED] minutes per month, with a total monthly care cost of [REDACTED]. (Respondent's Exhibit A, page 25; Testimony of [REDACTED]).
8. Appellant's guardians appealed that proposed reduction and the request for hearing was received by the Michigan Administrative Hearing System (MAHS) on [REDACTED], was assigned Docket No. 2013-59636 HHS.
9. Given the applicable policy and the fact that Appellant's appeal was filed prior to the effective date of the proposed reduction, the reduction was not implemented at that time and Appellant's HHS remained at [REDACTED] per month while that appeal was pending. (Respondent's Exhibit A, page 26).
10. While that appeal was pending, ASW [REDACTED] attempted to complete a home visit and reassessment with Appellant and her provider on [REDACTED] (Respondent's Exhibit A, page 22; Testimony of ASW [REDACTED]).
11. However, no one answered the door and ASW [REDACTED] had to telephone the primary telephone number and leave a message. (Respondent's Exhibit A, page 22; Testimony of ASW [REDACTED]).
12. That same day, [REDACTED] telephoned ASW [REDACTED] back to explain that she never received notice of the visit and had been staying in the hospital with Appellant's sibling since [REDACTED] (Respondent's Exhibit A, page 22; Testimony of [REDACTED] Testimony of ASW [REDACTED]).
13. [REDACTED] also informed ASW [REDACTED] that a nurse and an aide had been providing care to Appellant since [REDACTED] (Respondent's Exhibit A, page 22; Testimony of [REDACTED] Testimony of ASW [REDACTED]).

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14. ASW ██████████ then mailed a written Advance Action Notice to Appellant stating that her HHS would be suspended effective ██████████ because the ASW had been unable to complete the required face-to-face contact. (Respondent's Exhibit A, page 13).
15. The notice also provided that Appellant's guardians needed to schedule an appointment and that, unless the ASW was contacted by the ██████████, Appellant's case would be closed. (Respondent's Exhibit A, page 13).
16. That negative action notice further noted that the Department had been informed that the provider has not provided care for ██████████ since ██████████ because she was staying with Appellant's sibling at a hospital, and that Appellant was being cared for by nurse and an aide. (Respondent's Exhibit A, page 13).
17. On ██████████, ASW ██████████ was able to meet with Appellant and her aide in Appellant's home to discuss Appellant's needs and services. (Respondent's Exhibit A, page 23).
18. At that time, ASW ██████████ also noted that, as a hearing has been scheduled in Docket No. 2013-59636 HHS for ██████████ any further changes, if any are to occur, would be made after that hearing. (Respondent's Exhibit A, page 23).
19. On ██████████, Appellant's guardian/provider telephoned ASW ██████████ and informed her that the provider had returned to the home. (Respondent Exhibit A, page 24; Testimony of ██████████; Testimony of ASW ██████████).
20. The guardian/provider also confirmed that she had been at the hospital with Appellant's sibling between ██████████ and ██████████ and that Appellant's HHS had been provided by a nurse or an aide during that period. (Respondent Exhibit A, page 24; Testimony of ██████████ Testimony of ASW ██████████).
21. Also, on ██████████, the guardian/provider and ASW ██████████ held a visit and redetermination in Appellant's home. (Respondent Exhibit A, page 24; Testimony of ██████████ Testimony of ASW ██████████).
22. During that meeting, Appellant's provider provided documentation regarding how services have been and are being provided by her, the nurse, and the aide. (Respondent Exhibit A, page 24; Testimony of ██████████; Testimony of ASW ██████████).
23. She also indicated that she would elaborate on how services were being provided at the upcoming hearing. (Respondent Exhibit A, page 24).

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24. However, on ██████████, the hearing in Docket No. 2013-59636 HHS was dismissed by MAHS after it received a notice of withdrawal from Appellant's representative with respect to Appellant's request for hearing. (Respondent's Exhibit A, 8).
25. Appellant's HHS were reinstated as of ██████████, the date the provider returned to the home. (Respondent Exhibit A, page 26).
26. As the previous appeal regarding the reduction in services had been withdrawn, Appellant's HHS were reinstated at the reduced amount. (Respondent Exhibit A, page 26).
27. On ██████████, MAHS received a request for hearing filed on Appellant's behalf in this matter. (Respondent's Exhibit A, pages 9-15).
28. In that request, Appellant's co-guardian ██████████ indicated that she would like Appellant's services to remain at the previous level of ██████████ until this appeal is resolved. (Respondent Exhibit A, page 10).
29. The request also stated in the request for hearing that the matter had been previously submitted for hearing, but was subsequently withdrawn due to further changes being made and her son's hospitalization, which kept her from being able to attend the in-person hearing scheduled for ██████████ (Respondent Exhibit A, page 10).
30. The request further noted that Appellant's services were suspended due to her guardian's inability to meet with Appellant's ASW at the review meeting and that there has been a lack of coordination between Appellant's PDN and HHS services, which the Department of Human Services (DHS) is using as grounds for withdrawing HHS. (Respondent Exhibit A, page 11).
31. In ██████████ the Department also began the process of seeking recoupment from Appellant and her provider for the time periods when her previous appeal was pending and Appellant continued to receive HHS at the higher level. (Respondent's Exhibit A, page 24; Testimony of ██████████).

CONCLUSIONS OF LAW

As discussed above, Appellant wishes to appeal both the reduction of her HHS and the subsequent suspension of those services in September of 2013.

With respect to both issues, Appellant bears the burden of proving by a preponderance of the evidence that the Department erred.

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Here, for the reasons discussed below, the undersigned Administrative Law Judge finds that he lacks jurisdiction over the reduction in HHS and that Appellant failed to meet her burden of proof with respect to the suspension of HHS.

Reduction in Services

As an initial matter, the Department requested a dismissal of any claims regarding the reduction of services on the basis that any such claims are untimely.

The Social Security Act and the federal regulations which implement the Social Security Act require an opportunity for fair hearing to any recipient who believes the Department may have taken an action erroneously. See 42 CFR 431.200 *et seq.*

However, this Administrative Law Judge only has jurisdiction to hear cases brought timely and the opportunity for fair hearing is limited by a requirement that the request be made within 90 days of the CMH's negative action:

Request for hearing.

* * *

The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

42 CFR 431.221(d)

Here, it is undisputed that a notice of reduction was sent out on ██████████ and, while Appellant timely appealed that reduction, the request for hearing was later withdrawn and the matter was dismissed.

Moreover, the request for hearing in this case was not received by MAHS until ██████████ and it therefore clearly exceeds the █ day deadline for filing a request for hearing.

Accordingly, this Administrative Law Judge lacks jurisdiction to hear Appellant's untimely appeal regarding the reduction in her HHS.

Suspension of Services

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 (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.

The Department utilizes Adult Services Manuals (ASMs) to identify the types of services encompassed by HHS; how those services are assessed and approved; and any other aspect of the program.

For example, ASM 101, regarding Available Services, states in part:

Home Help Payment Services

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.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)

- Eating.
- Toileting.

- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Housework.

An individual must be assessed with at least one activity of daily living (ADL) in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

Note: If an individual uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the individual must be ranked a level 3 or greater on the functional assessment. This individual would be eligible to receive home help services.

Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

Assistive technology would include such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and handheld showers.

Expanded Home Help Services (EHHS)

Expanded home help services can be authorized for individuals who have severe functional limitations which require such extensive care that the service cost must be approved by the adult services supervisor/local office designee and/or the Department of Community Health.

Complex Care

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed on clients whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or client may be required in order to perform.

- Eating or feeding assistance.
- Catheters or leg bags.
- Colostomy care.
- Bowel program.
- Suctioning.
- Specialized skin care.
- Range of motion exercises.
- Dialysis (In-home).
- Wound care.
- Respiratory treatment.
- Ventilators.
- Injections.

* * *

Services not Covered by Home Help

- Supervising, monitoring, reminding, guiding, teaching or encouraging (functional assessment rank 2).
- Services provided for the benefit of others.
- Services for which a responsible relative is **able** and **available** to provide (such as house cleaning, laundry or shopping). A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18.

- Services provided by another resource at the same time (for example, hospitalization, MI-Choice Waiver).
- Transportation - See Bridges Administrative Manual (BAM) 825 for medical transportation policy and procedures.
- Money management such as power of attorney or representative payee.
- Home delivered meals.
- Adult or child day care.
- Recreational activities. (For example, accompanying and/or transporting to the movies, sporting events etc.)

Note: The above list is not all inclusive.

ASM 101, pages 1-3, 5 of 5

Additionally, ASM 120, regarding the Adult Services Comprehensive Assessment, provides in part:

The DHS-324, Adult Services Comprehensive Assessment, is the primary 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

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.
 - Use the DHS-27, Authorization To Release Information, when requesting client information from another agency.
 - Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation.. [sic] This form is primarily used for APS cases.
- Follow rules of confidentiality when home help cases have companion adult protective services cases; see SRM 131, Confidentiality.

* * *

Expanded Home Help Services (EHHS)

Expanded home help services exists if all basic home help services eligibility criteria are met and the assessment indicates the client's needs are so extensive that the cost of care cannot be met within the monthly maximum payment level of \$549.99.

Michigan Department of Community Health Approvals

When the client's cost of care exceeds \$1299.99 for **any** reason, the adult services specialist must submit a written request for approval to the Michigan Department of Community Health (MDCH).

Follow the **Procedures for Submitting Expanded Home Help Requests** found on the Adult Services Home Page. Submit the request with all required documentation to:

Michigan Department of Community Health
Long Term Care Services Policy Section
Capital Commons Building, 6th Floor
P.O. Box 30479
Lansing, MI 48909

MDCH will provide written documentation (DCH-1785) of approval. A new request **must** be submitted to the Michigan Department of Community Health whenever there is an increase in the cost of care amount. A new request is **not** required if the cost of care decreases below the approved amount set by MDCH.

Note: If an expanded home help case closes and reopens within 90 days and the care cost remains the same, a new MDCH approval is **not** required.

ASM 120, pages 1-2, 6-7 of 7

Following the initial comprehensive assessment, the Department must provide notice of its decision, as well as any subsequent change in services:

INTRODUCTION

Individuals who submit an application (DHS-390) for home help services or adult community placement must be given written notification of approval or denial for services. A written notice must be sent within the 45 day standard of promptness.

Clients with active service cases must be provided written notice of any change in their services (increase, reduction, suspension or termination).

Written Notification of Disposition

All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.

- DHS-1212, Advance Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

The adult services specialist must sign the bottom of the second page of all notices (DHS-1210, DHS-1212A, DHS-1212) before they are mailed to the client.

ASM 150, page 1 of 5

Moreover, if services are approved, a home help provider must be selected and enrolled pursuant to ASM 135:

PROVIDER SELECTION

The client has the right to choose the home help provider(s). As the employer of the provider, the client has the right to hire and fire providers to meet individual personal care service needs. Home help services is a benefit to the client and earnings for the provider.

The determination of provider criteria is the responsibility of the adult services specialist.

* * *

PROVIDER INTERVIEW

An initial face-to-face interview must be completed with the home help provider. A face-to-face or phone contact must be made with the provider at the six month review or redetermination to verify services are being furnished.

Explain the following points to the client and the provider during the initial interview:

- The provider is employed by the client **not** the State of Michigan.
- As the employer, the client has the right to hire and fire the provider.
- A provider who receives public assistance **must** report all income received as a home help provider to their family

independence specialist or eligibility specialist.

- The client and provider are responsible for notifying the adult services specialist within **10 business days** of any change in providers or hours of care.
- The provider and/or client is responsible for notifying the adult services specialist within **10 business days** if the client is hospitalized.

Note: Home help services **cannot** be paid the day a client is admitted into the hospital but **can** be paid the day of discharge.

- 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.
- **All** earned income must be reported to the IRS; see www.irs.gov.
- No federal, state or city income taxes are withheld from the warrant.
- Parents who are caring for an adult child do not have FICA withheld.

Note: Parents who wish to have FICA withheld must be assigned in ASCAP as other relative in the Provider Assignment screen.

- **All** individual providers will receive a W-2 by the Michigan Department of Community Health.
- Provider must display a valid picture identification card and social security card.
- The client **and** provider **must** sign the MSA-4676, Home Help Services Statement of Employment, before payments are authorized.

Note: Providers determined to be a business/agency are exempt from signing the MSA-4676.

- **All** providers **must** sign a MSA-4678, Home Help Services Provider Agreement, before payments are authorized.

Note: Providers are required to complete and sign the agreement only **once**. If there is a signature date on Bridges/ASCAP provider screen, another MSA-4678 does not need to be completed and signed.

PROVIDER ENROLLMENT

All home help providers **must** be enrolled in Bridges by a designee at the local county DHS office prior to authorizing payment. Once a provider is enrolled, Bridges will assign the provider a seven digit identification number. The adult services specialist must allow 24 hours from the time of enrollment for Bridges to interface with ASCAP.

Instructions for enrolling a provider on Bridges are found on the **Office of Training and Staff Development home page**. Instructions on assigning a provider in ASCAP are in the **ASCAP User Guide** located on the adult services home page.

ASM 135, pages 1-4 of 9

Additionally, regarding reviews of a beneficiary's HHS, ASM 155 provides:

CASE REVIEWS

Independent living services (home help) cases must be reviewed every six months. A face-to-face contact is required with the client, in the home.

A face-to-face or phone contact must be made with the provider at six month review and redetermination to verify services are being furnished.

Note: If contact is made by phone, the provider must offer identifying information such as date of birth and the last four digits of their social security number. A face-to-face interview in the client's home or local DHS office must take place at the next review or redetermination.

Six Month Review

Requirements

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- Verification of the client's Medicaid eligibility, when home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan, if applicable.
- Review of client satisfaction with the delivery of planned services.
- Reevaluation of the level of care to assure there are no duplication of services.
- Contact must be made with the care provider, either by phone or face-to-face, to verify services are being provided.

Documentation

Case documentation for **all** reviews must include:

- An update of the "Disposition" module in ASCAP.
- A review of **all** ASCAP modules with information updated as needed.
- A brief statement of the nature of the contact and who was present in the **Contact Details** module of ASCAP. A face-to-face contact entry with the client generates a case management billing.
- Documented contact with the home help provider.
- Expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- A record summary of progress in service plan.

Annual Redetermination

Procedures and case documentation for the annual review are the same as the six month review, with the following addition(s):

- A new DHS-54A certification, if home help services are being paid.

Note: The medical needs form for SSI recipients and Disabled Adult Children (DAC) is **only** required at the initial opening and is not required for the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and annually thereafter.

- Contact must be made with the care provider, either by phone or face-to-face, to verify services are being provided.

ASM 155, pages 1-2 of 2

Here, as discussed above, Appellant HHS services were suspended in ██████████ after ASW ██████████ was unable to complete a review as scheduled and learned that Appellant's provider had not been performing HHS because she was at the hospital with Appellant's sibling.

In response, Appellant's provider/guardian testified that they never received notice of the scheduled visit and they have never missed any appointments before.

However, ASW ██████████ credibly testified that she mailed a letter regarding the visit earlier and it appears that Appellant and his provider/guardian never received that notice due to Appellant's sibling's hospitalization. Moreover, the above policy clearly requires that Appellant's comprehensive assessment must be updated as often as necessary, but that, at a minimum, a face-to-face contact is required with the client, in the home, every ██████████ months. The Department was unable to complete that required face-to-face contact as scheduled in this case and therefore sent Appellant advance notice requiring a suspension and possible case closure.

The above policy also states that the Department may only pay for HHS provided by enrolled providers and, at the time of the suspension in this case, it had learned that Appellant's sole enrolled home help provider was unavailable and not providing any HHS because she was at the hospital with Appellant's sibling. Accordingly, as noted in the advance action notice, it could pay for HHS at that time.

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On ██████████, Appellant's guardian/provider telephoned ASW ██████████ and informed her that the provider had returned to the home. Appellant's HHS were then properly reinstated as of that date.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that he lacks jurisdiction over Appellant's claims regarding the reduction in HHS and that the Department properly suspended Appellant's HHS.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

Steven Kibit

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: ██████████

Date Mailed: ██████████

SK/db

cc: ██████████
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***** 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.