

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. 2014-10885 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 ██████████ ██████████ ██████████ ██████████ 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 sister; ██████████, 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; and ██████████, registered nurse and private duty nursing specialist; were also present or testified on the Department's behalf.

ISSUE

Did the Department properly deny Appellant's request for additional Home Help Services (HHS) and suspend his current 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 with spastic quadriplegia; nocturnal ventilation via tracheostomy; chronic respiratory failure; seizure disorder; and autistic disorder. (Respondent's Exhibit A, page 21).
2. Appellant's parents are his legal guardians. (Respondent's Exhibit A, pages 13-14).

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3. Appellant was referred for HHS in ██████████ and his case has been open since ██████████. (Respondent's Exhibit A, page 19).
4. Appellant's mother is and always has been the sole enrolled home help provider for Appellant. (Testimony of ██████████; Testimony of ██████████).
5. Appellant case was first reviewed for Expanded Home Help Services (EHHS) in ██████████ by RN ██████████. (Respondent's Exhibit A, pages 26, 30; Testimony of ██████████).
6. Subsequently, he was approved for ██████████ per month of HHS, effective ██████████. (Respondent's Exhibit A, pages 26, 30-31; Testimony of ██████████).
7. In ██████████, Appellant's HHS were reduced to ██████████ (Respondent's Exhibit A, page 31).
8. In ██████████, Appellant requested additional HHS. (Testimony of ██████████; Testimony of ██████████).
9. Given that Appellant was continuing to request EHHS, his request was again forwarded for review by ██████████. (Testimony of ██████████).
10. She conducted her review in ██████████ and made recommendations regarding that request. (Respondent's Exhibit A, pages 25, 32-35; Testimony of ██████████).
11. Appellant's former ASW, ██████████, was supposed to complete the processing of Appellant's request prior to retiring, but she failed to do so and Adult Services Supervisor ██████████ took over the case. (Testimony of ██████████).
12. However, while it appears that ██████████ did attempt to schedule a home visit in ██████████ and ██████████ did indicate that she and Appellant were available on the requested dates, no home visit was conducted at that time. (Respondent's Exhibit A, page 25).
13. Similarly, ██████████ recommendations regarding EHHS were never implemented or rejected, and no specific action was taken with respect to Appellant's request. (Respondent's Exhibit A, page 25).
14. Moreover, while ██████████ also noted that she held a telephone conference with ██████████ on ██████████ with respect to Appellant's services, once again no specific action was taken at that time with respect to Appellant's request for additional services. (Respondent's Exhibit A, page 25).

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15. By ██████████ ASW ██████████ had been assigned to Appellant's case and she and ██████████ again forwarded a request to the Department and ██████████ for EHHS for Appellant in the amount of ██████████ hours and ██████████ minutes per month, with a total monthly care cost of ██████████. (Respondent's Exhibit A,
16. However, that request for EHHS was never responded to and no action was taken by the Department. (Testimony of ██████████; Testimony of ██████████).
17. On ██████████ ASW ██████████ attempted to complete a home visit and reassessment with Appellant and his provider in Appellant's home. (Respondent's Exhibit A, pages 12, 26; Testimony of ASW ██████████).
18. However, no one answered the door and ASW ██████████ instead called the primary telephone number and left a message. (Respondent's Exhibit A, pages 12, 26; Testimony of ASW ██████████).
19. That same day, ██████████ telephoned ASW ██████████ back to explain that she never received notice of any scheduled home visit and that Appellant was in the hospital, and had been in the hospital since ██████████. (Respondent's Exhibit A, pages 12, 26; Testimony of ASW ██████████).
20. ASW ██████████ then mailed a written Advance Action Notice to Appellant that same day stating that his HHS would be suspended effective ██████████ because the ASW had been unable to complete the required face-to-face contact. (Respondent's Exhibit A, page 12).
21. The notice also provided that Appellant's guardians needed to schedule an appointment and that, unless the ASW was contacted by ██████████ Appellant's case would be closed. (Respondent's Exhibit A, page 12).
22. That negative action notice further noted that the Department had how been informed that Appellant had been hospitalized since ██████████, but was never informed about any such hospitalization previously. (Respondent's Exhibit A, page 12).
23. On ██████████, ASW ██████████ was informed that Appellant had returned home from the hospital, and a home visit and redetermination were then scheduled for the next day. (Respondent's Exhibit A, page 26).
24. During that home visit on ██████████ ASW ██████████ and ██████████ discussed Appellant's care needs and how those needs were being met by his home help provider, private duty nurse, and Community Living Supports (CLS) aide. (Respondent's Exhibit A, pages 26-27).

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25. However, ASW ██████ declined to reinstate Appellant's HHS at that time because she had questions regarding the nature and amount of services that Appellant's home help provider was performing. (Respondent's Exhibit A, pages 26-27).
26. In her notes, ASW ██████ wrote that she would contact the agencies providing Appellant's PDN and CLS in order to gather more information. (Respondent's Exhibit A, page 27).
27. Over ██████ weeks later, on ████████████████████ ASW ██████ attempted to get information from the agency providing CLS. (Respondent's Exhibit A, page 27).
28. Similarly, On ████████████████████, she contacted the agency providing PDN. (Respondent's Exhibit A, pages 27-28).
29. In neither case, did ASW ██████ receive any information from the other agencies. (Testimony of ASW ██████).
30. On ████████████████████, MAHS received a request for hearing filed on Appellant's behalf. (Respondent's Exhibit A, pages 8-14).
31. 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 9).
32. The request also stated that Appellant's year of ██████ review has never been finalized and his request for EHHS at that time was neither addressed nor granted. (Respondent's Exhibit A, page 10).
33. The request further noted that Appellant's services were improperly suspended due to his guardian's inability to meet with Appellant's ASW at the review meeting due to Appellant being hospitalized. (Respondent Exhibit A, page 10).
34. On ████████████████████ telephoned ASW ██████ regarding Appellant's services and ASW ██████ informed her that she still needed documentation from other agencies in order to accurately assess Appellant's services. (Respondent's Exhibit A, page 28).
35. ██████ stated that she would follow up with the other agencies and obtain the documentation. (Respondent's Exhibit A, page 28).

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36. On ██████████ telephoned ASW ██████ and informed her that Appellant's primary insurance was paying for Appellant's personal care needs at that time, but that she and Appellant's attorney were also working with ██████ to determine Appellant's HHS and that a request for an administrative hearing had also been filed. (Respondent's Exhibit A, page 29).
37. Based on that information, ASW ██████ and her supervisor decided to send another Advance Negative Action Notice. (Respondent's Exhibit A, page 29).
38. In that notice, mailed out on ██████████, the Department stated that Appellant's HHS would be suspended, effective ██████████ due to the fact that his primary insurance was covering all his care needs. (Respondent's Exhibit A, pages 15-18).
39. On ██████████ sent an email to ASW ██████ and ██████ indicating that Appellant's primary insurance was no longer paying for ██████████ care as of ██████████. (Petitioner's Exhibit 1, page 1; Testimony of ██████).
40. That email also noted that he was receiving CLS and PDN through the Habilitation Supports Waiver. (Petitioner's Exhibit 1, page 1).
41. Both ASW ██████ and ██████s denied receiving a copy of any email. (Testimony of ASW ██████; Testimony of ██████).

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 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 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** require 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

Finally, with respect to the coordination of HHS with other services, ASM 125 provides in part that:

PARTNERSHIPS

The adult services specialist has a critical role in developing and maintaining partnerships with community resources.

To facilitate these partnerships the adult services specialist will:

- Advocate for programs to address the needs of clients.
- Emphasize client choice and quality outcomes.
- Encourage access and availability of supportive services.

Work cooperatively with other agencies to ensure effective coordination of services.

Coordinate available resources with home help services in developing a services plan that addresses the full range of client needs.

Do **not** authorize home help services if another resource is providing the same service at the same time.

COMMUNITY MENTAL HEALTH (CMH)

Many clients are eligible for home help services while also receiving mental health services through the local community mental health services programs (CMHSPs) or prepaid inpatient health plans (PIHPs).

Clients, who live in unlicensed settings where home help services may be provided, include:

- Own home/apartment, either living alone or with roommates or relatives. Client's name is on the lease or mortgage.

- Home of a family member.
- Supported independent setting (formerly called SIP homes). The lease is held by an individual that is **not** also the provider of other services such as home help.

Note: The instrumental activities of daily living in shared living arrangements must be divided by **one half**.

Community Living Supports (CLS)

Clients eligible for home help services authorized by the adult services specialist may also receive community living supports (CLS) authorized through the local community mental health services pro-grams (CMHSPs) or prepaid inpatient health plans (PIHPs). Community living supports services cannot **duplicate** or **replace** home help services.

The client's plan should clearly identify where home help and community living supports are **complementary**. The adult services specialist determines the need for services based on the DHS-324, Adult Services Comprehensive Assessment. If the client is receiving the maximum authorized through home help and still needs additional hands on assistance with some ADLs and/or IADLs in order to remain at home, community living supports services may be used to provide that additional direct physical assistance which exceeds the cost of care determined by DHS.

Unlike home help, which only provides direct hands on assistance with ADLs and IADLs, community living supports services typically are used for skill development or supervision. In such situations, the use of both home help and community living supports is permitted as the services are different and not a duplication.

The community living supports services may not supplant or replace home help services. The client must exhaust all available services under home help before seeking community living supports.

ASM 125, pages 1-2 of 12

Here, as discussed above, Appellant has been receiving HHS since ██████████ and the issues on appeal involve the denial of Appellant's requests, starting in ██████████, for additional services and the suspension of the HHS Appellant was receiving in ██████████

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

Denial

Appellant's request for hearing first states that Appellant's year of ██████ review has never been finalized and his request for EHHS at that time was neither addressed nor granted. (Respondent's Exhibit A, page 10).

In response, the Department requests a dismissal of any such claim on the basis that it is 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 notice of the Department's negative action: "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, Appellant first requested additional HHS, including EHHS, in ██████████ and, while that request was reviewed by ██████ in ██████████ and she made various recommendations at that time, no action was ever taken with respect to that request and no notice of approval or denial was ever issued by Appellant's case workers. (Respondent's Exhibit A, pages 25, 32-35; Testimony of ██████; Testimony of ██████).

Appellant's case workers testified that they did forward another request for EHHS to the Department and ██████ in ██████████, but ██████ testified that she was unaware of any such request; it was never responded to; and no action was ever taken by the Department. (Testimony of ██████; Testimony of ██████; Testimony of ██████).

The Department has had ample time to respond to Appellant's requests for additional HHS and by failing to take any action with respect to that request, it has essentially denied it.

Moreover, as no notice of action was ever mailed, the ██████ day deadline for filing a request for hearing with respect to that denial never began to run and Appellant's request for hearing is timely.

Additionally, given that both ██████ and ██████ case workers have all determined that Appellant's request for additional services should have been granted, at least in part, the record reflects that the Department erred in denying Appellant's request.

Accordingly, the Department's actions should be reversed and it must initiate a redetermination of Appellant's eligibility for services and the amount of services he should have been authorized for from ██████████ onward.

Suspension

The request for hearing further asserts that Appellant's services were improperly suspended due to her guardian's inability to meet with Appellant's ASW at the review meeting due to Appellant being hospitalized. (Respondent Exhibit A, page 10).

As testified to by ASW ██████████ and explained in the Advance Action Notice explaining the suspension, Appellant's services were suspended after Appellant and his provider/guardian failed to appear for a scheduled home visit and ASW ██████████ was unable to complete the required face-to-face contact. (Respondent's Exhibit A, pages 12, 26; Testimony of ASW ██████████. Moreover, that notice also provided that, while the Department had been informed that day that Appellant had been hospitalized since ██████████, the Department was never previously informed of any such hospitalization. (Respondent's Exhibit A, pages 12, 26; Testimony of ASW ██████████).

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in suspending his services. For the reasons discussed below, this Administrative Law Judge finds that Appellant has failed to meet that burden of proof in this case.

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 six months. See ASM 120, page 1 of 7; ASM 155, page 1 of 2. 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.

In response, Appellant's provider/guardian testified that they never received notice of the scheduled visit and they have never missed any appointments before. (Testimony of ██████████). 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 hospitalization. (Testimony of ██████████; Testimony of ASW ██████████).

Moreover, while is understandable why Appellant and his provider/guardian were unable to be present for the home and failed to reschedule prior to the day of the visit, this Administrative Law Judge would also note that Appellant and his provider/guardian were responsible for notifying ASW ██████████ within ██████████ business days if the client is hospitalized, see ASM 135, page 3 of 9, and they clearly failed to do so in this case.

Additionally, as also noted in the notice of suspension, Appellant had been in the hospital since ██████████ and services provided by another resource at the same

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time, such as a hospital, are not covered by the home help program. See ASM 101, page 5 of 5. Appellant therefore could not be receiving HHS at that time regardless and his case, which was never closed, would need to be reassessed after he was discharged.

Appellant did return from the hospital in ██████████ and, while the required home visit and reassessment were held on ██████████, his services were not reinstated at that point. (Respondent's Exhibit A, pages 26-27).

The Department's decision not to reinstate Appellant's services at that time was also proper. According to ASW ██████████, she declined to reinstate Appellant's HHS at that time because she had questions regarding the nature and amount of services being performed by Appellant's home help provider given the presence of a private duty nurse and a CLS aide, in addition to the fact that the home help provider had indicated that she did not provide all of the approved HHS. (Testimony of ASW ██████████; Respondent's Exhibit A, pages 26-27).

The Department argues that the decision not to reinstate services at that time was proper given that policy prohibits the authorization of HHS if another resource is providing the same service at the same time. See ASM 125, page 1 of 12. However, as acknowledged by Adult Services Supervisor ██████████ the only witness or representative from the Department to address the issue, the applicable policy also provides that HHS must be exhausted prior to a beneficiary seeking CLS (ASM 125, page 2 of 12) and the proper procedure would therefore have been to authorize the HHS that Appellant needs, coordinate with other agencies, and have the any other services duplicating Appellant's HHS removed (Testimony of ██████████).

Nevertheless, given the circumstances of this case, the decision not to reinstate services immediately upon Appellant's return from the hospital and the completion of the required assessment was proper given the questions remaining regarding who would be providing the previously authorized HHS.

Appellant's mother is and always has been the sole enrolled home help provider for Appellant. (Testimony of ██████████; Testimony of ██████████). However, it is also undisputed that the enrolled provider has not been providing all of the approved HHS and, instead, regularly pays others to provide the necessary care out of the home help payments. (Testimony of ██████████). Appellant's home help provider/guardian also testified that she had always used that arrangement and that Appellant's previous case worker was both aware of how HHS were being provided and had approved that system. (Testimony of ██████████).

This Administrative Law Judge does not find Appellant's provider to be credible on whether any such arrangement was approved by the previous ASW worker and, even if it was approved, such an arrangement clearly violates the applicable policy as all home help providers must be enrolled in the program and the Department may only pay for services provided by those enrolled providers. Here, any others providers are not enrolled providers with respect to Appellant and it is not clear if they would even meet

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enrollment criteria. Similarly, given the improper arrangement, Appellant's provider has been submitting improper logs.

Accordingly, given the continuing issues surrounding HHS and the need to clarify those issues, Appellant and his representatives have failed to meet his burden of proving by a preponderance of the evidence that his services should have been reinstated at the time he returned from the hospital and the redetermination was conducted.¹

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, while the Department properly suspended Appellant's HHS in ██████████ ██████████, it also improperly failed to act on and, thereby denied, Appellant's requests for additional HHS, starting in ██████████

IT IS THEREFORE ORDERED THAT:

The Department's actions are **REVERSED IN PART** and it must initiate a redetermination of Appellant's eligibility for services and the amount of services he should receive from ██████████ onward.

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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¹ Appellant also appears to challenge a subsequent notice of suspension issued by the Department as well as its failure to reinstate his HHS after the request for hearing was filed. However, those subsequent events are beyond the scope of this hearing as this Administrative Law Judge's jurisdiction is limited to reviewing the issues raised in the request for hearing and in light of the information available to the Department at the time it made those disputed decisions.

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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.