

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**  
P.O. Box 30763, Lansing, MI 48909  
(517) 335-2484; Fax: (517) 373-4147

**IN THE MATTER OF:**

██████████,

Appellant.

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Docket No. 2014-34627 HHS  
Case No. 84124168

**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 the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appearing on behalf of the Appellant and offering testimony was ██████████. The Appellant also appeared and offered testimony. ██████████, Appeals Review Officer, represented the Department of Community Health. ██████████, Adult Services Worker (ASW) appeared as a witness for the Department.

**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. As of ██████████, the Appellant was receiving HHS.
2. On ██████████, the ASW mailed to the Appellant a Home Visit letter. The letter was sent in the ordinary course of business and indicated an assessment date of ██████████. (Exhibit A, p. 13; Testimony)
3. On ██████████, the ASW went to the Appellant's residence to conduct the assessment. The Appellant was not available and the assessment did not take place. (Exhibit A, p. 15; Testimony)
4. On ██████████, the ASW mailed to the Appellant a Home Visit letter. The letter was sent in the ordinary course of business and indicated an assessment date of ██████████. (Exhibit A, p. 14; Testimony)
5. On ██████████, the ASW sent the Appellant an Advance Negative Action letter. The letter indicated the Appellant was unavailable for the

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first visit and that if the Appellant is not home for the second visit the Appellant's HHS case would be closed. (Exhibit A, pp. 6-8; Testimony)

6. On [REDACTED], the ASW went to the Appellant's residence to conduct the assessment. The Appellant was not available and the assessment did not take place. (Exhibit A, p. 15; Testimony)
7. On [REDACTED], the Michigan Administrative Hearing System received a Request for Hearing from the Appellant. The request for hearing indicated the Appellant had left messages for the ASW to call him at [REDACTED]. (Exhibit A, p. 4)

**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.

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 101 (12-1-2013) (hereinafter "ASM 101") addressed the issue of payment services for Home Help at the time of the denial in this case:

**Payment Services for Home Help**

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.

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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.
- Light Housecleaning.

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. [ASM 101, pages 1-2 of 4.]

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Regarding the assessment discussed above, ASM 120 (12-1-2013) (hereinafter “ASM 120”) provided:

**Functional Assessment**

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the client’s ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping
- Laundry
- Light Housework

Functional Scale ADL’s and IADL’s are assessed according to the following five-point scale:

1. Independent: Performs the activity safely with no human assistance.
2. Verbal Assistance: Performs the activity with verbal assistance such as reminding, guiding or encouraging.
3. Some Human Assistance: Performs the activity with some direct physical assistance and/or assistive technology.
4. Much Human Assistance: Performs the activity with a great deal of human assistance and/or assistive technology.

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5. Dependent: Does not perform the activity even with human assistance and/or assistive technology.

HHS payments may only be authorized for needs assessed at the 3 level or greater.

An individual must be assessed with at least one Activity of Daily Living 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.

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for activities of daily living and instrumental activities of daily living.

\* \* \*

### **Time and Task**

The worker will allocate time for each task assessed a rank of 3 or higher, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a **guide**. The RTS can be found in ASCAP under the Payment module, Time and Task screen. When hours exceed the RTS, rationale **must** be provided. [ASM 120, pages 2-4 of 6.]

Moreover, with respect to the authorization of payments, ASM 140 (12-1-2013) (hereinafter "ASM 140") states:

### **ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)**

The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. The Adult Services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.

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*No payment can be made unless the provider has been enrolled in Bridges. Adult foster care, homes for the aged and home help agency providers must also be registered with Vendor Registration; see ASM 136, Agency Providers.*

**Note:** The adult services home page provides a link to the provider enrollment instructions located on the Office of Training and Staff Development web site.

Home help services payments to providers must be:

- *Authorized for a specific period of time and payment amount.* The task is determined by the comprehensive assessment in ASCAP and will automatically include tasks that are a level three or higher.
- Authorized **only** to the person or agency actually providing the hands-on services.

**Note:** An entity acting in the capacity of the client's fiscal intermediary is not considered the provider of home help and must not be enrolled as a home help provider; see ASM 135, Home Help Providers.

- Made payable jointly to the client and the provider.

**Exception:** Authorizations to home help agency providers are payable to the provider only. There are circumstances where payment authorizations to the provider only are appropriate, for example, client is physically or mentally unable to endorse the warrant. All single party authorizations must be approved by the supervisor.

- Prorate the authorization if the MA eligibility period is less than the full month. [ASM 140, page 1 of 3 (italics added).]

With respect to Reviews, ASM 155 (12-1-2031) (hereinafter "ASM 155") states:

## **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:

- 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.

\* \* \*

The Department in this matter provided evidence that several attempts were made to meet with the Appellant for an annual redetermination and that at no point in time did the redetermination take place.

The Appellant in this case indicated the ASW never contacted him regarding the scheduling of the assessment and did not call him at his new phone number.

Under the mailbox rule "a letter mailed in the due course of business is received."<sup>1</sup> Such evidence is admissible without further evidence from the records custodian that a particular letter was actually mailed.<sup>2</sup> "Moreover, the fact that a letter was mailed with a return address but was not returned lends strength to the presumption that the letter was received."<sup>3</sup> The challenging party may rebut the presumption that the letter was received by presenting evidence to the contrary.<sup>4</sup>

The Department has produced sufficient evidence of its business custom with respect to addressing and mailing of the notices in question. Under the mailbox rule, the mere execution of the delivery in the usual course of business rebuttably presumes

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<sup>1</sup> *Good v Detroit Automobile Inter-Insurance Exchange*, 67 Mich App 270 (1976).

<sup>2</sup> *Good supra* at 275.

<sup>3</sup> *Id* at 276.

<sup>4</sup> See *id.*

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subsequent receipt by the addressee.<sup>5</sup> The Department has produced sufficient evidence of its business custom with respect to the mailing of the home visit letters allowing it to rely on this presumption. The Appellant, on the other hand, has not come forward with sufficient evidence to rebut the presumption. Therefore, I find that the letters in question were mailed and received.

Additionally, the Petitioner's testimony regarding his phone number is weak. Although the Petitioner testified he had changed his phone number in ██████████ and promptly notified the Department of the change, the Appellant's own hearing request states he had allegedly contacted the Department several times in ██████, and requested they call him back at his old phone number.

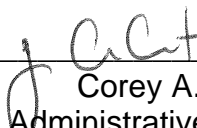
Therefore, based on the evidence presented, the Department properly closed Appellant's case for the Appellant's failure to be available and participate in the mandated in-home review. Appellant was given ample opportunity to participate in an in-home review and he failed to do so. Appellant can always reapply for home help services.

**DECISION AND ORDER**

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

**IT IS THEREFORE ORDERED THAT:**

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

  
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Corey A. Arendt  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

cc:

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██████████  
██████████

CAA ██████

<sup>5</sup> *Good v Detroit Automobile Inter-Insurance Exchange*, 67 Mich App 270 (1976).

[REDACTED]  
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Date Signed: [REDACTED]

Date Mailed: [REDACTED]

**\*\*\* 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.