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

IN THE MATTER OF:

Docket No. 15-002775 HHS

[redacted]i, [redacted]l, [redacted] [redacted]

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 the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]2[redacted] Appellant's provider, [redacted] appeared and testified on Appellant's behalf. Appellant also testified on his own behalf. [redacted], Appeals Review Officer, represented the Department of Health and Human Services. (Department or Respondent). [redacted] Adult Services Worker (ASW) appeared as a witness for the Department.

Respondent's Exhibit A1-A38 and Appellant's Exhibit 1 were admitted as evidence.

ISSUE

Did the Department properly terminate Home Help Services (HHS) for the Appellant?

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 [redacted] year-old Medicaid beneficiary, date of birth [redacted]e[redacted], who is diagnosed with diabetes, congestive heart failure, sleep apnea, chronic obstructive pulmonary disease, lumbar stenosis, neuropathy, prostate cancer. (Respondent's Exhibit A page 16)

2. Appellant has been receiving HHS since [redacted] (Respondent's Exhibit A page 15)

3. Respondent was scheduled for a home visit on [redacted]

4. On [redacted], Appellant contacted the Department Adult Services worker to tell her that he needed to cancel his appointment and reschedule because he had a bad lung infection and needed IV injections.

5. On [redacted], the ASW notified Appellant via telephone that the new home visit date would be [redacted] between [redacted] am to [redacted] pm. (Respondent's Exhibit A page 19)

6. On [redacted] the ASW sent Appellant an Advance Negative Action notice stating that Home Help Services would be suspended effective [redacted] because Appellant contacted the caseworker to cancel the case review scheduled for [redacted]. Case reviews are required. The ASW had rescheduled it to [redacted] from [redacted] to [redacted] pm. If Appellant was not present for the rescheduled date, then the negative action would occur. (Respondents Exhibit A page 5)

7. On [redacted], at [redacted] pm the ASW came to Appellant's home and knocked on the apartment door. She could see someone walk past the door but no one answered. The ASW left the premises. (Respondent's Exhibit A page 19).

8. On [redacted], at [redacted] pm and [redacted] pm, Appellant contacted the ASW via telephone and left voice mail messages to ask that she come back because he was real sick and was in the bathroom when she came to the door. (Respondent's Exhibit A page 19)

9. The ASW did not return to conduct the home visit, even though she did see his phone messages within abou[redacted] minutes of her attempt to make the home visit. (Respondent's Exhibit A page 19)

10. On [redacted], the ASW contacted Appellant via telephone and invited the Appellant to come to her office for the home visit. Appellant declined as he was "very sick" and stated that he wanted a hearing. (Respondent's Exhibit A page 19)

11. On [redacted], the Michigan Administrative Hearing System received a Request for Hearing from Appellant. (Respondent's Exhibit A page 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.

Home Help Services 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.
>
> 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.]

Regarding the assessment discussed above, Adult Services Manual 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.

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.]

ASM 120, page 1, specifically states:

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.

Moreover, with respect to the authorization of payments, Adult Services Manual 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.
>
> *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, Adult Services Manual 155 (5-1-2013) (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 ASW testified on the record that on [redacted] she went to Appellant's house and knocked on his door at [redacted] pm. No one came to the door. The ASW left the scene. She did not return to Appellant's apartment because she did not see his voicemail messages until [redacted] minutes after Appellant called and asked her to come back to his house for the scheduled in-home assessment visit. The ASW did not think it was reasonable to turn around and go back to Appellant's home, even though she received the telephone messages in a timely manner. Since she saw someone walk in the apartment she determined that the visit was refused. The ASW stated that she waited until the next day and phoned Appellant to invite him to come into the office to see her for the scheduled visit and Appellant refused to do so because he was "very sick". She did not offer to reschedule the visit because the case was being transferred to a different caseworker. The ASW did not make contact with Appellant's provider.

Appellant's provider testified that he thought he heard someone knock at the door but Appellant was sick and throwing up and the provider was attending Appellant.

Appellant stated that he has been very sick for a long time and that he contacted the ASW when he was first scheduled for an in-home visit to tell her that he had to go to the hospital for and IV treatment for pneumonia on [redacted] so he needed to reschedule that meeting. Appellant stated that he was home on [redacted] and was still very sick. He was waiting for the caseworker to come but he got sick and vomited and had diarrhea all over the floor. He had a coughing fit and could not breathe and his provider was helping him when the ASW came to knock on his door. He called her five minutes later to request that she come back but the ASW did not return his call.

On [redacted] Appellant's treating physician, [redacted] wrote a letter for Appellant which states:

> Please be advised that I am the primary care physician for Mr. Randal Wisniewski. Patient had refractory pneumonia and severe bronchitis for several weeks. Patient is still being treated because he is still not feeling good. Patient was unable to have a home visit on [redacted] because he was at the office for IV treatment for pneumonia. He also missed a home visit on [redacted] because he was vomiting and had diarrhea. Patient was advised not to go to his court hearing due to chronic problems including emphysema and neuropathic pain. Patient should do the hearing by phone. (Appellant's Exhibit #1)

Based on the evidence presented, the Department did not properly close Appellant's HHS case based upon his refusal to participate in mandated in-home reviews. There is no evidence on the record that Appellant refused the in-home review. He appropriately contacted the ASW to re-schedule the [redacted] appointment because he was very sick. The home visit was scheduled for [redacted] between [redacted] pm. The ASW alleges that she arrived at [redacted] pm and knocked on the door. When no one answered the door, she left, but did not answer her phone and received voice mail messages from Appellant at [redacted] pm and [redacted] pm.

Credible testimony on the record indicates that Appellant attempted to have the ASW return to his address on [redacted] to conduct the in-home assessment within [redacted] minutes. It seems reasonable to this Administrative Law Judge that the ASW could have either returned to the house to conduct the in-home assessment on [redacted] or the ASW should have re-scheduled the in-home assessment with Appellant once he requested that she come back or the meeting be rescheduled. Department policy does not state that only [redacted] attempt to conduct a home visit should happen before the case is terminated. The ASW did not offer Appellant a [redacted] chance to conduct the in-home assessment. Department policy explicitly states that the in-home assessment must be conducted face to face with Appellant in his home not on the telephone. The telephone contact may be made with the Provider, not the recipient of the HHS.

Bridges Policy Glossary (4-1-2015), page 28 defines **Good Cause** as a circumstance which is considered a valid reason for not complying with a requirement. Appellant's medical doctor has supplied sufficient evidence that Appellant has been very ill in recent months and in fact, could not come to the hearing, but needed to conduct this hearing over the telephone. The physician provided a doctor's excuse, stating that Appellant had a doctor's appointment on the date of the first scheduled home visit and that Appellant was very sick on the date the ASW came to the home for Appellant's scheduled in-home visits.

The evidence on the record does not indicate that Appellant refused to conduct the in-home assessment at any time. Evidence on the record indicates that Appellant is not mobile and requires assistance with mobility, medication, transferring, bathing, housework, laundry, shopping and meal preparation. His testimony that he was too sick

to come to the door is credible under the circumstances. He did miss his scheduled appointment, but attempted to contact the ASW immediately. He provided good cause for his lack of availability at [redacted] pm when the ASW came to his house. The Department's actions are reversed under the circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department has not established by the necessary competent, material and substantial evidence on the record that the termination of Appellant's Home Health Services was proper under the circumstances.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **REVERSED**. The Department is **ORDERED** to reinstate Appellant's HHS case, set a mutually convenient date with Appellant and his Provider for the in-home assessment and conduct the in-home assessment with Appellant and his provider within [redacted] days of the receipt of this decision for determination of Appellant's continued eligibility for Home Health Services.

Landis Y. Lain
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Signed; [redacted]

Date Mailed: [redacted]

LYL/db

cc: [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.