STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-003574 HHS
Case No. [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]. Appellant appeared and testified. Appellant's provider appeared as a witness.

[redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Worker (ASW), and [redacted], Adult Services Supervisor, (ASS) from [redacted] County DHS testified as witnesses for the Department.

ISSUE

Did the Department properly close Appellant's Home Help Services (HHS) case on the grounds that the redetermination was not completed?

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 male beneficiary of the welfare Medicaid and SSI programs. Appellant has been a beneficiary of the HHS program since [redacted]. (Exhibit A.8).

2. Appellant's diagnoses are: osteoarthritis, DJD; by self-report lower back pain, fatigue. (Exhibit a.9).

3. In [redacted] [redacted], Appellant's case was due for an annual redetermination interview. The ASW issued an internal letter formulated by [redacted] County DHS District Manager but did not issue an ASCAP letter. The Department had no documentation of the letter formulated by the [redacted] District Manager. Appellant did not receive the District Manager's letter but was home when the ASW showed up for a face-to-face interview on [redacted].

4. The Department determined that Appellant was eligible for continuing HHS benefits which would be continued after an interview with Appellant's provider was conducted. (Exhibit A.11).

5. The Department and the provider failed to connect for the requiremed provider interview. (Testimony).

6. On [redacted] the Department issued a DHS-1212 closure letter on the grounds that the provider did not complete the redetermination process. (Exhibit A.6).

7. On [redacted] Michigan Administrative Hearing System (MAHS) received a Request for Hearing stating in part that he never received any letters. (Exhibit A.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 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.

Adult Services Manual 101 (11-1-2011) (hereinafter "ASM 101") and Adult Services Manual 120 (5-1-2012) (hereinafter "ASM 120") address the issues of what services are included in Home Help Services and how such services are assessed. For example, ASM 101 provides:

> **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. [ASM 101, pages 1-2 of 4 (italics added).]

ASM 120 states:

> **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
>
> ADLs and IADLs 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.

Home Help 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. [ASM 120, pages 2-3 of 5.]

Moreover, with respect to the review of HHS once they are already granted, Adult Services Manual 155 (11-1-2011) 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.

According to the above policy, the ASW must have face-to-face contact with a care provider at least once a year.

Here, the Department's argues that it issued the [redacted] District Manager's internal letter for the face-to-face interview, but failed to issue an ASCAP letter. In addition, the Department contends that it informed Appellant to inform his provider to contact the Department on the following Monday between the hours of 10 a.m. to 4 pm.

Appellant argues that he never received a letter regarding an appointment, which is why the provider was not present. Appellant also testified that he does not recall being instructed to tell his provider to appear at the local office on the following Monday. Appellant's provider testified that she attempted to contact the ASW a number of times by phone, but to no avail.

First, it is noted that policy does not require the provider to be present at the home visit. However, as noted above, policy does require contact with the provider to ensure that services are being delivered.

Here, there were a number of unusual facts regarding the handling of this case-such as the [redacted] District Manager drafting internal letters to supplant an ASCAP letter.

In addition, at hearing, the ASW argued that the DHS-1212 allows the client 10 days to respond. This is not correct-while the Department might customarily give clients 10 days after an advance negative action to correct a problem, this is a customary practice, not required by policy, and not indicated on the DHS-1212. As such is not stated on the DHS-1212, a client would have no knowledge or information regarding a 10 day opportunity to correct a problem. The 10 day notice is simply to reinstate a negative action pending the outcome of a request for an administrative hearing. Federal law requires the continuation of benefits in such circumstances.

The purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record.

Here, even if the evidence clearly shows that the Department failed to respond to phone calls, and/or failed to follow the correct procedure regarding the issuance of an "ASCAP letter," such would not be reversible error. Policy mandates contact with the provider, without which benefits cannot continue. Here that contact did not take place. Thus, there can be no continuation of benefits in such cases.

Appellant may reapply.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department closure of Appellant's Home Help Services case is supported by the DHS policy and procedure and thus,

IT IS THEREFORE ORDERED THAT:

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

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

JS/[redacted]

Date Signed: [redacted]

Date Mailed: [redacted]

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 March 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.