STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2010-16086 HHS
Case No. [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] was represented by her chore provider, [redacted].

[redacted] represented the Department of Community Health. [redacted], appeared as a witness on behalf of the Department. [redacted], was present at the hearing.

A Dismissal Order dated [redacted], was inadvertently sent by the State Office of Administrative Hearings and Rules. It is hereby rescinded and replaced by this Decision and Order.

ISSUE

Did the Department properly authorize Home Help Services (HHS) payments to 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. The Appellant is a [redacted] year old Medicaid beneficiary who applied for Home Help Services.

2. The Appellant resides with her daughter, who is reportedly employed outside of the home.

3. The Appellant's doctor certified on a DHS 54A medical needs form that the Appellant has a medical need for assistance with some activities of daily living and some instrumental activities of daily living. The 54A further indicates the Appellant's daughter is her chore provider.

4. An in home comprehensive assessment was conducted [redacted], by the Department's worker.

5. The Department's worker and the Appellant were the only two (2) people present at the assessment. The Appellant requested assistance with shopping, cleaning, laundry, meal preparation, and grooming.

6. The Appellant received functional ability ranks of three (3) or above for the tasks of grooming, housework, laundry, shopping, and meal preparation. The Department's worker testified that the Appellant is unable to do her own hair, requires assistance with laundry, and can warm up food for herself.

7. The Department's worker approved payment assistance for the tasks the Appellant indicated she required help with. The payment assistance check is expected to gross [redacted] per month. A chore provider who is not the Appellant's daughter was enrolled as her provider.

8. The Appellant's alleged chore provider is dissatisfied with the payment assistance authorized for the Appellant, thus she requested a hearing.

9. The Department informed the Appellant a hearing had been requested on her behalf and that she had not signed the request for hearing. The Appellant thereafter signed the request for hearing.

10. At hearing, the Appellant did not present direct evidence of her needs, she deferred to her alleged chore provider to testify. She stated that she had taken 1000 mg of a type of medication and described herself "doped up".

11. The Appellant's alleged chore provider indicates she drives from [redacted] to [redacted] per week and spends [redacted] per day providing care for the Appellant, receiving only [redacted] per month.

12. The Appellant's alleged provider asserted she grooms the Appellant, provides transportation to one (1) to two (2) doctor's appointments weekly, prepares three (3) meals per day, picks up all her prescriptions, performs all housework, all laundry, and distributes her medications daily.

13. The Department's worker testified she did inquire about medications at the comprehensive assessment and the Appellant went and got them herself and showed them all to her and told her which medication had been prescribed by

which doctor. She said they had not discussed her ability to take them without assistance from another person.

14. The Appellant takes Leprocil, Depokote, Seroquel and Tramadol.

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 (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.

Program requirements are set forth in Adult Services Manual item 362, below:

> **GENERAL SERVICES REQUIREMENTS** The client must sign an Adult Services Application (DHS-390) to receive ILS. An authorized representative or other person acting for the client may sign the DHS-390 if the client:
>
> • Is incapacitated, **or**
>
> • Has been determined incompetent, **or**
>
> • Has an emergency. A client unable to write may sign with an "X", witnessed by one other person (e.g., relative or department staff). Adult services workers must not sign the services application (DHS-390) for the client. Eligibility must be determined within 45 days of the signature date on the DHS-390.
>
> **Note:** ASSIST (Automated Social Services Information and Support) requires a disposition within 30 days of the registered request. See ASSIST User Manual (AUM) 150-7/8. The DHS-390 is valid indefinitely unless the case is closed for more than 90 days.
>
> **ELIGIBILITY CRITERIA**
>
> **Independent Living Services** The following **nonpayment** related independent living services are available to any person upon request **regardless** of income or resources:
> • Counseling.
> • Education and training.

- Employment.
- Family planning.
- Health related.
- Homemaking.
- Housing.
- Information and referral.
- Money management.
- Protection (For adults in need of a conservator or a guardian, but who are not in any immediate need for protective service intervention.)

Home Help Services (HHS) Payment related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:

- The client must be eligible for Medicaid.
- Have a scope of coverage of:
  - 1F or 2F,
  - 1D or 1K, (Freedom to Work), **or**
  - 1T (Healthy Kids Expansion).
- The client must have a need for service, based on
  - Client choice, **and**
  - Comprehensive Assessment (DHS-324) indicating a functional limitation of level 3 or greater in an ADL or IADL.
- Medical Needs (DHS-54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:
  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

ASM 362, 12-1-2007

Manual Item 363 addresses what a comprehensive assessment consists of, as well as other program procedures.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

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 customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

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 customer'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
- 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.

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

Time and Task

The worker will allocate time for each task assessed a rank of 3 or higher, based on the 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.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven hours/month for laundry
- 25 hours/month for meal preparation.

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements.

A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment. The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy

Service planning is person-centered and strength-based.
Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the caregiver, if applicable.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

• Strengthening families and individuals.
• The role of family in case planning.
• Coordinating with all relevant community-based services, and
• Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the Client does not perform activities essential to the caring for self. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.
- The kinds and amounts of activities required for the client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client does not perform. Authorize HHS only for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. Unable means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS-54A.

- Do not authorize HHS payments to a responsible relative or legal dependent of the client.
- The extent to which others in the home are able and available to provide the needed services. Authorize HHS only for the benefit of the client and not for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for the same time period).

Good Practices Service plan development practices will include the use of the following skills:

• **Listen actively** to the client.
• Encourage clients to **explore options** and select the appropriate services and supports.
• Monitor for **congruency** between case assessment and service plan.
• Provide the necessary supports to **assist** clients **in applying for resources**.
• Continually **reassess** case planning.
• Enhance/preserve the client's **quality of life**.
• **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

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 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:

Requirements:

- 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.

ELIGIBILITY FOR HOME HELP SERVICES
Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid(MA)

Verify the client's Medicaid/Medical aid status. The client may be eligible for MA under one of the following:

• All requirements for MA have been met, **or**

• MA deductible obligation has been met. The client must have a scope of coverage of:

• 1F or 2F, **or**
• 1D or 1K (Freedom to Work), **or**
• 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rate by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

Necessity For Service
The adult services worker is responsible for determining the necessity and level of need for HHS based on:

• Client choice.
• A complete comprehensive assessment and determination of the client's need for personal care services.

• Verification of the client's medical need by a Medicaid enrolled medical professional. The client is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:

•• Physician.
•• Nurse practitioner.
•• Occupational therapist.
•• Physical therapist.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form. The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services. If the medical needs form has not been returned, the adult services worker should follow-up with the client and/or medical professional. If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary. Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.

Payment for Medical Exams:
The Medicaid card is to be used to pay for medical professional charges for examinations or tests to certify the client's need for services and for completing the DHS-54A for MA recipients. Use the Examination Authorization/Invoice for Services (DHS-93) to pay for professional charges for non-MA clients. Payment is limited to the medical procedures and tests necessary to certify the client's need for home help services. See SRM 234, Diagnostic Fee Schedule.

Medical Review Team (MRT)
If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT evaluation is needed. The local office designee will forward the packet to the regional Disability Determination Services (DDS) MRT. The MRT will make a determination and return the forms. See L-letter 00-130,

June 20, 2000. The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.

Expanded Home Help Services (EHHS)

EHHS may be authorized if **all** of the following criteria are met:

- The client is eligible for HHS.
- The client has functional limitations so severe that the care cost cannot be met safely within the monthly maximum payment.
- The local office director/supervisory designee has approved the payment (EHHS $550-$1299.99) **or** the Department of Community Health (DCH) has approved the payment (EHHS $1300 or over). All EHHS requests for approval must contain:
- Medical documentation of need, e.g., DHS-54A, **and**
- An updated DHS-324 **and** written plan of care which indicates:
  - How EHHS will meet the client's care needs **and**
  - How the payment amount was determined.

Note: See adult services home page for Expanded Home Help Services Procedure Guideline under Training Materials/Job Aids, developed by the Department of Community Health. **Service Animal** Payment for maintenance costs of a service animal may be authorized if **all** of the following conditions are met:

- The client is eligible for HHS.
- The client is certified as disabled due to a specific condition such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury.
- The service animal is certified as professionally trained by a recognized agency to meet specific needs of the client.
- The HHS plan documents that the service animal will be used primarily to meet specific client personal care needs.

Service animal maintenance may be authorized for a client in an alternative care setting (AFC or HA). Authorize payment for maintenance costs of a service animal if the client meets **all** eligibility criteria.

COORDINATION OF HHS WITH OTHER SERVICES
Coordinate available home care services with HHS in developing a services plan to address the full range of client needs. Do **not** authorize HHS if another resource is providing the same service at the same time.

Supported Independent Living Programs (SIP)
Clients in supported independent living program homes (SIP) may be eligible for HHS payments. See L-Letter 97-278.

Services not Covered by Home Help Services
Do **not** authorize HHS payment for the following:

- Supervising, monitoring, reminding, guiding 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;
- Services provided free of charge;
- Services provided by another resource at the same time;
- Transportation - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.
- Money management, e.g., power of attorney, representative payee;
- Medical services;
- Home delivered meals;
- Adult day care.

Note: If it appears the client's primary need is for adult foster care (AFC) or foster care is being provided without a license, the case should be referred to the local AFC licensing consultant.

ASM 363, 9-1-2008

At hearing, the Appellant's chore provider asserted she requires greater compensation for all she does for the Appellant, and should have had payment assistance authorized for assistance with medication. The Department's witness testified at hearing that she discussed medications with the Appellant. The Appellant went and got them and told her which ones had been prescribed by which doctor. She was able to do this with the worker and never asserted she was unable to take them without assistance. There is scant evidence in the record supporting a finding she should have payment assistance approved for medication assistance, as was asserted by her provider.

The request for hearing states the provider is transporting the Appellant to her medical appointments one (1) to two (2) times per week. She is not eligible for payment assistance through the Home Help Services program for this task. The Appellant may seek assistance for this through her eligibility worker at the Department of Human

Services. The adult services worker may have informed her of this fact. If not, she should be certain to inform her clients who are in need of transportation assistance with medical appointments of how to obtain it.

Additional disputed aspects include the amount of payment authorized for the tasks of grooming, meal preparation, laundry, shopping, and errands. This ALJ will indicate that the credibility of the Appellant's alleged provider is at issue due to the fact that the Medical Needs form completed by the Appellant's provider states her daughter is her chore provider. Yet, her daughter is not enrolled as the provider. It was asserted the daughter is unable to be the provider owing to her status as otherwise employed. It is possible the daughter's intent was to be a provider for and then only after speaking with the doctor decided she was unable to do it, however, this is not found that likely given the assertions from the witness who testified she is the actual provider. The witness indicated she drives from [redacted] to [redacted] a week to provider "total care" to the Appellant. She further asserted she spends [redacted] per day providing the care, performing virtually all housework, laundry, shopping, meal preparation, grooming her hair, and dispensing her medication, as well as transporting her to one (1) or two (2) medical appointments per week. She does this for the sum of [redacted] per month. This is so unlikely as to be characterized as absurd. If she is actually providing [redacted] of personal care, [redacted] per week she is being paid well under [redacted] per hour. Simply stated, this is not credible on its face. If she is actually providing the care she asserts at hearing, she is being taken advantage of and may need a legal guardian appointed to protect her own interests. Furthermore, if the Appellant actually requires [redacted] why she does. She would not get this level of personal care and service if she were found eligible for institutional care. The only evidence of record about her needs indicates she is bi-polar, depressed to the point of not taking care of herself, has high blood pressure, and asthma. This does not evidence a need for [redacted] per day of physical care-taking and housekeeping. So, this ALJ suspects the claim that the Appellant is having this level services provided by someone who drives into the city [redacted] rather than her own daughter, with whom she resides, is not true. This casts a pall on the claims that the Appellant requires a greater level of assistance than was approved. The testimony from the Appellant's provider is not found credible for these reasons.

It could be that the provider is electing to provide "total care" to someone who does not actually require it but has asserted she does. Although the Appellant has a DHS 54A certifying she has a medical need for assistance with some activities of daily living and instrumental activities of daily living, a certification from a doctor that a person has a medical need for assistance with a task does not support a finding they require "total care". Assistance with a task is different from doing it for them. There is no reason for this ALJ to believe the doctor has any familiarity with program parameters, that is why the Department's worker has the responsibility to determine whether an applicant qualifies for payment assistance or not. The doctor would not know that a functional

rank of three (3) or greater is a requirement before payment assistance for any given task can by authorized. The assistance needed by the Appellant may be simple supervision, reminding or guidance (which are ranked two (2)). That is why a doctor's certification is an insufficient basis to authorize assistance payments. The specific level of assistance is determined by the worker, based upon a comprehensive assessment of the applicant's functional abilities and needs and in conjunction with the program parameters. In this case, the worker did determine the Appellant had a functional rank of three (3) for some tasks, thus she authorized a minimal level of payment assistance for them. The functional rank of three (3) is indicative of the Appellant's ability to participate in her own care to a greater extent than others who receive functional ranks of four (4) or five (5). Because the Appellant has been determined able to participate in her own care to a large extent, the payment authorization implemented by the Department at case opening is found sufficient to meet her needs. Frankly, this ALJ finds the determinations of the worker quite generous. Reviewing the evidence of record, there is no showing the Appellant is unable to do anything for herself should she be reminded, supervised or guided. The documentary evidence in the record does not support a finding she would require a greater level of assistance than was approved by the Department's worker and the testimony from the alleged provider is not credible.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly determined the Appellant's Home Help Services payment.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

_____

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No. 2010-16086 HHS
Decision and Order

cc: [redacted]

Date Mailed: 06/04/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.