STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Docket No. 2011-4846 HHS
Case No. 4369985

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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], the Appellant, appeared on her own behalf. [redacted], represented the Department. [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services (HHS) case?

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 [redacted] Medicaid beneficiary who has been diagnosed with lumbar herniated disc. (Exhibit 1, page 10)

2. The Appellant was a prior participant in the HHS program with a monthly total care cost around [redacted]. (Appellant Testimony)

3. On or about [redacted], the Appellant was referred to the Home Help Services program and a DHS 54-A Medical Needs Form was printed. (Exhibit 1, page 5)

4. On [redacted], an Adult Services Worker (ASW) made a visit to the Appellant's home and a DHS 390 Independent Living Services Application was printed. (Exhibit 1, page 5)

5. The ASW did not schedule the home visit in advance or complete a full comprehensive assessment, rather she stopped by when she was in the area after a cancellation and asked the Appellant what she needed help

with. (ASW Testimony)

6. The Appellant has a monthly spend down of $[redacted] that must be met each month before she becomes Medicaid eligible for that month. (Exhibit 1, page 9)

7. On [redacted], the ASW received an email from the Appellant's Medicaid Eligibility Specialist stating that the Appellant has opted to use her personal care services provider's expense toward her Medicaid deductible and is aware she will be responsible to use her excess income to pay her provider as these services will not be paid by the Department. (Exhibit 2)

8. The ASW determined the Appellant would qualify for HHS hours with a monthly total care cost of $[redacted]. (Exhibit 1, page 8)

9. The Appellant's Medicaid deductible exceeds the amount of the HHS payment the ASW determined she was potentially eligible for.

10. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating that her Home Help Services case would terminate effective [redacted], because her spend down exceeds the cost of her home help. (Exhibit 1, pages 4-6)

11. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's Request for Hearing. (Exhibit 1, page 3)

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 Adult Services Manual addresses the issue of a comprehensive assessment and service plan development:

> **COMPREHENSIVE ASSESSMENT**
>
> The Adult Services Comprehensive Assessment (FIA-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 client in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the client'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 redetermination.
- 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 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.

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 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.

IADL Maximum Allowable Hours

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

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 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.

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 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.
- 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 same time period).

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.

Adult Services Manual (ASM) 363, 9-1-2008,
Pages 2-15 of 24

The Adult Services Manual also addresses eligibility for the HHS program:

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.

Adult Services Manual (ASM) 362, 12-1-2007 pages 1-2 of 5.

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 of 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 (sic) 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.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and the ES.

Conditions of eligibility:

- The client meets all MA eligibility factors except income.
- An ILS services case is active on CIMS (program 9).
- The client is eligible for personal care services.
- The cost of personal care services is **more** than the MA excess income amount.
- The client agrees to pay the MA excess income amount to the home help provider.

Inform the ES of the amount of personal care services (HHS care cost) **and** the amount of personal care required but not approved for HHS payment, i.e., monthly payment does not meet total care needs.

If **all** the above conditions have been met, the client has met MA deductible requirements. The ES will send written notification of the MA effective date and the MA excess income amount.

Upon receipt of the ES notification, enter the client's deductible amount in the **"Resources"** tab of the **"Basic Customer"** module in **ASCAP**.

> **Note:** Use the Services Approval Notice (DHS-1210) to notify the client of HHS approval when MA eligibility is met through this option. The notice must inform the client that the HHS payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA excess income amount (deductible) each month.
>
> Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.
>
> Notify the ES in writing of any changes in the client's personal care needs. The ES will send written notification of any changes in the monthly MA excess income amount.
>
> MA eligibility under this option **cannot** continue **if:**
> - The client no longer needs personal care; **or**
> - The cost of personal care becomes **equal to or less than** the MA excess income amount.
>
> *Adult Services Manual (ASM) 363, 9-1-2008 pages 7-8 of 24*

The Adult Services Worker (ASW) did not complete comprehensive assessment as described in the Adult Services Manual. Rather, she stopped by the Appellant's home on [redacted], without any advance notice for a home visit because she was in the area and had a cancellation. The ASW did not go over each of the functional activities with the Appellant to determine her abilities and needs. The ASW just asked the Appellant what she needed help with. She also made several assumptions based on the Appellant being on the couch in the living room and the appearance of the home. (ASW Testimony)

On [redacted], the ASW received an email from the Appellant's Medicaid Eligibility Specialist stating that the Appellant has opted to use her personal care services provider's expense toward her Medicaid deductible and is aware she will be responsible to use her excess income to pay her provider as these services will not be paid by the Department. (Exhibit 2) This is consistent with the Adult Services Manual policy regarding the Medicaid Personal Care Option.

It is not clear when the ASW used the information gathered from the home visit to determine the HHS hours the Appellant was potentially eligible for each month, $[redacted]. (Exhibit 1, page 8) The ASW then determined that the Appellant was not eligible for the HHS program because the amount of her monthly spend-down, $[redacted], exceeds the potential HHS payment, $[redacted], she would receive from the Department each month. Accordingly, the Department issued the termination notice on [redacted].

The Department's determination to terminate the Appellant's HHS case can not be supported by the evidence. The HHS time and task authorizations that determined the potential monthly HHS payment amount were based on a home visit that as described by the ASW, was not sufficient to be considered a comprehensive assessment under Department policy. Accordingly, the termination of the Appellant's HHS case must be reversed. A new home visit shall be scheduled to complete a comprehensive assessment to determine the Appellant's needs and potential HHS monthly payment.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department did not properly terminate the Appellant's HHS case.

IT IS THEREFORE ORDERED THAT:

The Department's decision is REVERSED. The Department shall schedule a new home visit appointment with the Appellant to complete a comprehensive assessment to determine the Appellant's needs and potential HHS monthly payment.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/8/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules March 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 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.