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

IN THE MATTER OF:

[redacted],

Docket No. 2012-61566 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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant was present and testified on his own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker ("ASW"), and [redacted], Adult Services Supervisor, appeared as witnesses for the Department.

ISSUE

Did the Department properly reduce the Appellant's Home Help Services ("HHS") application?

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 has been receiving Home Help Services.

2. The Appellant is diagnosed with multiple medical problems which affect his functional status; including: degenerative arthritis of the lumbar spine, chronic pain syndrome, hepatitis c, arthritis of hands and legs, tremors in left hand, copd, osteoarthritis and osteopenia.

3. The Appellant requires assistance with bathing, grooming dressing transferring, mobility, medication laundry, shopping, housework and meal preparation.

4. The ASW completed a home call in conjunction with a review on [redacted].

5. The ASW noted 3 adults reside in the Appellant's home.

6. The ASW made adjustments to the time authorized for the provider to complete some of the tasks required by the Appellant as a result of her evaluation in [redacted].

7. The ASW sent notice of reduction in payment authorization [redacted], with an effective date of [redacted].

8. The ASW reduced the time authorized for mobility assistance from 20 minutes per day to 14. Time for laundry was reduced from 7 hours per month to 1 hour per month. Time for shopping was reduced from 5 hours 1 minute per month to 43 minutes per month. Medication assistance was reduced from 7 hours 31 minutes per month to 2 hours per month.

9. The Appellant contested the reductions in home help authorizations by requesting a hearing.

10. On [redacted], the Appellant's Request for Hearing was received.

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 (ASM) sets forth eligibility criteria, program mission and goals. The current, updated policy states:

> **ELIGIBILITY CRITERIA**
>
> **GENERAL**
>
> Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened to supportive services to assist the client in applying for Medicaid.
>
> Home help services payments cannot be authorized prior to establishing Medicaid eligibility and a face-to-face assessment completed with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

Requirements

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
- Appropriate Level of Care (LOC) status.

Medicaid/Medical Aid (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

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

Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

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 coordinate implementation with the eligibility specialist.

Conditions of eligibility:

- The client meets all Medicaid eligibility factors except income.

- An independent living services case is open.
- The client is eligible for home help services.
- The cost of personal care services is **more** than the MA excess income amount.

If **all** the above conditions have been satisfied, the client has met MA deductible requirements. The adult services specialist can apply the personal care option in ASCAP. The deductible amount is entered on the **MA History** tab of the Bridges **Eligibility** module in ASCAP.

Use the DHS-1210, Services Approval Notice to notify the client of home help services approval when MA eligibility is met through this option. The notice must inform the client that the home help payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA deductible amount 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.

Changes in the client's deductible amount will generate a system tickler from Bridges.

MA eligibility under this option **cannot** continue if the cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. A completed DHS-54A or veterans administration medical form are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

Necessity For Service

The adult services specialist is responsible for determining the necessity and level of need for home help services based on:

- Client choice.
- A completed DHS-324, Adult Services comprehensive Assessment. 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 IADLs if the assessment determines a need at a level 3 or greater.

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Appropriate Level of Care Status

Verify client's level of care to avoid duplication of services. The level of care will determine if the client is enrolled in other programs. The level of care information can be found in ASCAP under the **Bridges Search** or **Bridges Eligibility**

module, **MA History** tab; see ASM 125 Coordination With Other Services for a list of level of care codes.

Adult Services Manual 105
effective November 1, 2011

ASM 115 ADULT SERVICES REQUIREMENTS

APPLICATION FOR SERVICES (DHS-390)

The client must complete and sign a DHS 390, Adult Services Application to receive independent living services.

An authorized representative or other person acting for the client may sign the DHS-390 if the client either:

- Is incapacitated.
- Has a court-appointed guardian.

A client unable to write may sign with an X, witnessed by one other person (for example, relative or department staff). The adult services specialist **must not** sign the DHS-390 on behalf of the client.

The DHS-390 remains valid unless the case record is closed for more than 90 days.

MEDICAL NEEDS FORM (DHS-54A)

The DHS-54A, Medical Needs form must be 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 (M.D. or D.O.).
- Nurse practitioner.
- Occupational therapist
- Physical therapist.

Note: A physician assistant (PA) is not an enrolled Medicaid provider and **cannot** sign the DHS-54A.

The medical needs form is only required at the initial opening for SSI recipients and disabled adult children (DAC). All other Medicaid recipients must have a DHS-54A completed at the initial opening and annually thereafter.

The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.

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**. Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional.

Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.

The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is **before** the date on the DHS-390, payment for home help services must begin on the date of the application.

Example: The local office adult services unit receives a DHS-54A signed on 1/18/2011 but a referral for home help was never made. The adult services staff enters a referral on ASCAP and mails an application to the client. The application is returned to the office with a signature date of 2/16/2011. Payment cannot begin until 2/16/2011, or later, if the provider was not working during this time period.

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.

Veteran's Administration (VA)

The Michigan Department of Community Health (MDCH) will accept a DHS-54A completed by a Veteran's Administration physician or the VA medical form in lieu of the medical needs form.

COMPREHENSIVE ASSESSMENT (DHS-324)

Conduct a face-to-face interview with the client in their home to assess the personal care needs. Complete the DHS-324, Adult Services Comprehensive Assessment which is generated from the Adult Services Comprehensive Assessment Program (ASCAP); see ASM 120, Adult Services Comprehensive Assessment.

SERVICE PLAN

Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the assessed needs of the client. The ILS service plan is developed whenever an issue is identified in the comprehensive assessment; see ASM 130, Service Plan.

CONTACTS

The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.

An initial face-to-face interview must be completed with the home help provider in the client's home or local DHS office. A face-to-face or phone contact must be made with the provider at the next review or 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.

ADULT SERVICES REQUIREMENTS § 115

The ASM provides the following instruction to the worker in implementing the policy:

PERSON CENTERED PLANNING

The adult services specialist views each client as an individual with specific and unique circumstances, and will approach case planning holistically, from a person-centered, strength-based perspective.

Person-centered, strength-based case planning focuses on the following:

- Client as **decision-maker** in determining needs and case planning.
- Client **strengths and successes,** rather than problems.
- Client as their **own best resource.**
- Client **empowerment.**
- The adult services specialist's role includes **being an advocate** for the client. **As advocate, the specialist will:**

  ••Assist the client to become a self-advocate.

  ••Assist the client in securing necessary resources.

••Inform the client of options and educate him/her on how to make the best possible use of available resources.

••Promote services for clients in the least restrictive environment. Participate in community forums, town meetings, hearings, etc. for the purpose of information gathering and sharing.

••Ensure that community programming balances client choice with safety and security.

••Advocate for protection of the frail, disabled and elderly.

••Promote employment counseling and training services for developmentally disabled persons to ensure **inclusion** in the range of career opportunities available in the community.

Adult Services Manual (ASM)
11-1-2012

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.

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 IADLs if the assessment determined 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.

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Time and Task

The specialist 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.

An assessment of need, at a ranking of 3 or higher, does not automatically guarantee the maximum allotted time allowed by the reasonable time schedule (RTS). **The specialist must assess each task according to the actual time required for its completion.**

Example: A client needs assistance with cutting up food. The specialist would only pay for the time required to cur the food and not the full amount of time allotted under the RTS for eating.

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

Proration of IADLs

If the client does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for each task. Assessed hour for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as home help services are **only** for the benefit of the client.

Note: This does not include situations where others live in adjoined apartments/flats or in a separate home on shared property and there is no shared, common living area.

In shared living arrangements, where it can be **clearly** documented that IADLs for the eligible client are completed

separately from others in the home, hours for IADLs do not need to be prorated.

Example: Client has special dietary needs and meals are prepared separately; client is incontinent of bowel and/or bladder and laundry is completed separately; client's shopping is completed separately due to special dietary needs and food is purchased from specialty stores; etc.

Adult Services Manual (ASM) 120, 11-1-2011,
Pages 1-4 of 6

Advance Notice

The [redacted], Advance Negative Action Notice indicates that the Department intends to make the reductions to the Appellant's case effective [redacted]. The Code of Federal Regulations, Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

§ 431.211 Advance notice.

The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.
§ 431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a recipient;
(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the recipient's physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
(b) The facts have been verified, if possible, through secondary sources.

The Department did not send an Advance Negative Action Notice informing the Appellant that his payment authorization would be reduced. The Department sent a payment approval notice indicating a new payment authorization in a lower amount than the Appellant previously was authorized to receive. As of the hearing date, no Advance Negative Action Notice has been sent to the Appellant. The Payment approval Notice sent was mailed [redacted] and had an effective date of [redacted]. This is prohibited by the Adult Services Policy, State and Federal Law. This Department error must be remedied. The payment authorization must be restored to its previous amount of $[redacted], dating back to [redacted].

The ASW and the Appellant each provided testimony at hearing regarding the Appellant's service needs. The ASW provided testimony about reductions made and the reasons therefore. The Appellant provided testimony explaining why he disagreed. The Department offered to settle the matter, however the Appellant was unwilling to withdraw his hearing request and indicated he wanted to proceed to decision.

This ALJ finds the reduction taken for mobility is proper. It is based upon the reasonable time and task developed by the Department. No evidence establishing a reason to exceed the recommended time and task was entered into the record. The reduction will stand.

Grooming was reduced from 4 hours per month to 1 hour 9 minutes per month. The ASW testified the reduction was based upon the report of needing 1 haircut per week and assistance with shaving. The Appellant did not provide any evidence contesting this reduction or supporting a reason to reverse the ASW's reduction. The reduction shall stand

The remaining reductions are too large to be sustained. The Appellant takes 15 medications per day, some of them multiple times. His need for assistance with medication is not in dispute, however the amount of time authorized for it is. The previous level of assistance authorized was 15 minutes per day. The ASW reduced it to 2 minutes per day. At hearing she conceded she could have authorized it for 8 minutes per day. This ALJ finds the previous level of 15 minutes per day was reasonable given the number of medications taken, level of assistance needed with them and the number of times they have to be taken. It is no small or unimportant matter to keep 15 medications straight and administered properly.

The authorization for shopping was reduced from 5 hours 1 minute per month to 43 minutes per month. The Appellant is ranked a 4 for this task, thus 43 minutes per month is inadequate. It is also inconsistent with the Adult services policy, even for a shared household. One half the maximum allowable is reasonable for shopping because the Appellant lives with other adults. Shopping shall be adjusted to 2.5 hours per month.

Laundry was previously authorized for 7 hours per month, the maximum allowable time under normal circumstances. The ASW reduced it to 1 hour per month. The Appellant is ranked a 4 for this task. The ASW admits he can sort and fold only. The reduction is too severe to provide him the help he needs to get the task accomplished. The policy manual supports authorizing ½ the maximum allowable time for laundry in the Appellant's circumstances, thus this authorization shall be adjusted to 3.5 hours per month.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly determined that the authorization for home help services on behalf of the Appellant at the most recent assessment.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is PARTIALLY AFFIRMED AND PARTIALLY REVERSED. The Appellant's time for shopping, laundry and medication assistance shall be adjusted consistent with this decision. The authorization for mobility and grooming is affirmed; however, not its retroactive application. Because the Department never sent an advance negative action notice, the previously authorized payment must be restored to its earlier level, dating back to [redacted]. When the new authorization is calculated, if it is lower than

$[redacted] per month, an Advance Negative Action Notice must be sent with 10 days advance notice before its effective date. If the new payment authorization is higher than $[redacted] it shall have the most immediate practicable effective date from the date of calculation.

\s\

Jennifer Isiogu
Administrative Law Judge
For James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/15/2012

***** 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.