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) 373-4147

IN THE MATTER OF:

Docket No. 2011-7553 REM

[redacted],
Appellant
_____/

DECISION AND ORDER

This case was returned to the Michigan Administrative Hearing System (MAHS) pursuant to order of the [redacted], [redacted] Judicial Circuit Court, [redacted] County based on the stipulation signed by the parties [redacted]

After due notice, prehearing conferences were held on [redacted] and [redacted]. A hearing commenced on [redacted] continued on [redacted], and was completed on [redacted]

Attorney [redacted], appeared on behalf of the Appellant. [redacted] Personal Representative of the Appellant's Estate and daughter of the Appellant, appeared and testified.

[redacted], Assistant Attorney General, represented the Department on REMAND. [redacted], General Services Program Manager, [redacted] Community Resources Volunteer Services Coordinator, [redacted] Retired Community Resources Volunteer Services Coordinator, [redacted], Program Manager, and [redacted] former General Services Program Manager appeared as witnesses for the Department.

ISSUES

1) Did the Department properly authorize the Appellant's medical transportation reimbursement payments?

2) Did the Department properly authorize the Appellant's Home Help Services (HHS) payments?

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 was a Medicaid beneficiary who received medical transportation reimbursement and HHS payments.

2. The Appellant had a history of multiple medical conditions including: weight loss, mesenteric insufficiency, diabetes mellitus, arteriosclerotic heart disease, foot ulcer, vascular disease, blindness, macular degeneration, osteomyelitis, renal failure requiring dialysis, hypertension, congestive heart failure, diabetic retinopathy, hallux valgus deformities of both feet, neuropathy, left wrist fracture [redacted], osteoperosis, dementia, end stage renal disease, peripheral vascular disease, and anemia. (Circuit Court Record, Tab 4, DSS-54A Medical Needs Forms dated [redacted], [redacted], [redacted] and [redacted]; Circuit Court Record, Tab 8 letters from Infectious Disease Specialists dated [redacted], [redacted] and [redacted], DSS-54A Medical Needs forms dated [redacted], [redacted], FIA-54 Medical Needs Forms dated [redacted], [redacted] and letter from [redacted])

3. The Appellant's daughter provided medical transportation to the Appellant in a personal vehicle between [redacted] and [redacted]. (Uncontested)

4. The Appellant was reimbursed for Medical Transportation mileage at the personal vehicle rate of [redacted] per mile between [redacted] and [redacted] totaling [redacted]. (Uncontested)

5. On [redacted] and [redacted] the Department issued Client Notices to the Appellant stating they could not pay more than [redacted] per mile for medical transportation. The second page of the notice, the hearing request form and an explanation of the appeal rights, was included with the [redacted] notice. (Circuit Court Record, Tab 8, Client Notices dated [redacted] and [redacted]

6. The Appellant's daughter was her enrolled HHS provider. (Uncontested)

7. On [redacted], the Department issued a Services Approval Notice to the Appellant indicating she was authorized for HHS with a monthly care cost of [redacted] for [redacted] through [redacted] and a monthly care cost of [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval Notice dated [redacted]

8. On or about [redacted], the Appellant's HHS monthly care cost was increased to [redacted]. (Circuit Court Record, Tab 8, Reasonable Time Schedule dated [redacted]

9. On [redacted], the Department issued a Services Approval Notice to the Appellant indicating the HHS monthly care cost was increased to [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval notice dated [redacted]

10. On [redacted], the Department issued a Services Approval Notice to the Appellant indicating the HHS monthly care cost was increased to [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval notice dated [redacted]

11. On [redacted], the Department issued a Services Approval Notice to the Appellant indicating the HHS monthly care cost was increased to [redacted] effective [redacted] A Memo was also sent to the Appellant's daughter [redacted]. (Circuit Court Record, Tab 8, Services Approval notice dated [redacted] and Memo dated [redacted]

12. On [redacted], the Department issued a Services Approval Notice to the Appellant indicating the HHS monthly care cost was increased to [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval notice dated [redacted])

13. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's request for hearing contesting medical transportation mileage reimbursement and adult chore services payments. (Circuit Court Record, Tab 13, Request for an Administrative Hearing and [redacted] Client Notice)

14. On [redacted], telephone hearing proceedings began with ALJ [redacted]. (Circuit Court Record, Tab 10)

15. On [redacted] the Appellant died. (Circuit Court Record, Tab 1, Certificate of Death)

16. [redacted] granted several adjournments and held some continued telephone hearing proceedings through [redacted] [redacted] (Circuit Court Record, Tabs 5-10)

17. On [redacted], ALJ [redacted] issued an Order of Dismissal. (Circuit Court Record, Tab 1, Order of Dismissal)

[1] In April 2011, the State Office of Administrative Hearings and Rules changed to the Michigan Administrative Hearing System.
[2] It is noted that the transcripts and documentary records of the hearing proceedings with [redacted] are not complete.

18. Honorable [redacted] Judicial Circuit Court, [redacted] County Ordered the matter remanded based upon the Stipulation to Remand the Matter to the Michigan Department of Community Health Administrative Tribunal that was signed by the parties [redacted] indicating the appeal must be pursued by the personal representative of the estate of the Appellant. (Stipulation to Remand Matter to the Michigan Department of Community Health Administrative Tribunal)

19. On [redacted], the Appellant's daughter was appointed and qualified as personal representative of the Appellant's estate. (Letters of Authority for Personal Representative)

20. On [redacted], the State Office of Administrative Hearings and Rules received a letter requesting a pretrial conference with documentation of the appointment of a personal representative. (Request for Pre-Trial Conference)

21. On [redacted], Administrative Law Manager [redacted] issued an Order for Remand pursuant to the [redacted] Judicial Circuit Court in the County of [redacted] Stipulation and Order. (Order for Remand)

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.

On [redacted], the Appellant filed a hearing request contesting the medical transportation reimbursement and Home Help Services payments issued in this case. (Circuit Court Record, Tab 13, Request for an Administrative Hearing and Client Notice) The Appellant died on [redacted] (Circuit Court Record, Tab 1, Certificate of Death) On [redacted], ALJ [redacted] issued an Order of Dismissal based on the Appellant's death. (Circuit Court Record, Tab 1, Order of Dismissal) No final decision on the merits of the case was issued from the [redacted] administrative hearing proceedings.

Honorable [redacted] Judicial Circuit Court, [redacted] County Ordered the matter remanded based upon the Stipulation to Remand the Matter to the Michigan Department of Community Health Administrative Tribunal that was signed by the parties [redacted] indicating the appeal must be pursued by the personal representative of the estate of the Appellant. (Stipulation to Remand Matter to the Michigan Department of Community Health Administrative Tribunal)

On [redacted], the Appellant's daughter was appointed and qualified as personal representative of the Appellant's estate. (Letters of Authority for Personal Representative) However, it was not until [redacted] that the State Office of Administrative Hearings and Rules received a letter requesting a pretrial conference with documentation that a personal representative of the estate had been appointed. (Request for Pre-Trial Conference)

In accordance with the Stipulation to Remand the Matter to the Michigan Department of Community Health Administrative Tribunal, the personal representative of the estate can pursue the appeal originally filed by the Appellant on [redacted]

The personal representative of the Appellant's estate is requesting a review of the payments issued from [redacted] through [redacted] The Code of Federal Regulations, Chapter 42 § 431.206 and § 431.210-214 addresses the Appellant's rights with respect notice of agency actions. Pursuant to 42 CFR § 431.231(d), the Department must allow an applicant or recipient a reasonable time, not to exceed [redacted] days from the date that notice of action is mailed, to request a hearing. However, there is evidence that the Department did not always send notices with appeal rights to the Appellant. Specifically, in the partial transcripts available from the [redacted] hearing proceedings, the former General Services Program Manager testimony indicated that it appeared notices containing appeal rights were not always sent to the Appellant regarding her HHS case. (Circuit Court Record, Tab 10, Pages 17-18) Further, the evidence does not indicate the second page of the Client Notice, the hearing request form and an explanation of the appeal rights, was included with the [redacted] denial of medical transportation reimbursement at more than [redacted] per mile. (Circuit Court Record, Tab 8, Client Notices dated [redacted] Accordingly, this ALJ will not limit the scope of this hearing to only actions taken within the [redacted] days prior to the Appellant's [redacted] request for hearing.

However, it is noted that due to abnormally long period under review and length of time since the [redacted] hearing request was filed, at this time there is limited availability of the Department policies that were in effect during the entire contested time period as well as documentation from the Appellant's Department of Human Services case file. The Department policy manuals are periodically revised. The computerized database of the older versions of the Department policy manuals does not go all the way back to [redacted] The evidence further indicates there were issues with the availability or documentation from the Appellant's case file for the [redacted] administrative hearing proceedings. These issues regarding the availability of documentation from the Department of Human Services case file were unfortunately compounded by the certified record of the [redacted] administrative hearing proceedings being incomplete itself. Additionally, there was a [redacted] year delay from when the personal representative was appointed in [redacted] to when the [redacted] letter requesting a pre-trial conference was filed in accordance with the [redacted] Circuit Court Stipulation to Remand the Matter to the Michigan Department of Community Health Administrative Tribunal. This ALJ can only complete de-novo review of the merits of the case based upon the available evidence.

Medial Transportation Reimbursement

The Appellant is contesting being paid at the rate for personal vehicles rather than the rate for volunteer service drivers for medical transportation mileage reimbursement between [redacted] and [redacted]. (Appellant's Closing Brief, pages 21-23) Policy addressing medical transportation coverage under the State Medicaid Plan is found in the Program Administrative Manual (PAM), 825 Medical Transportation. The oldest version of this policy that could be found went into effect [redacted] and states:

> **Vehicles**
>
> If inter-city bus transportation is used (e.g., Greyhound), allow ticket charge per person (one way or round trip).
>
> If alternative transport is not available and mileage reimbursement is necessary, pay 12 cents per mile for all **personal** vehicles. This includes the recipient, relatives, friends, neighbors, etc.
>
> Pay 21 cents per mile only for those who are registered volunteer services drivers, foster care parents, commercial non-emergency medical transport vehicles, nonprofit agencies, taxis, and vans operated by medical facilities or public entities such as health agencies.
>
> Do not authorize payment for "waiting time" or multiple trips for a single medical visit.
>
> Program Administrative Manual (PAM), 825,
> Effective 7-1-1997, Page 7 of 16

The Medical Transportation policy was periodically updated. There were updates regarding the vehicle rates in August 1999:

> **Vehicle Rates**
>
> The following are reimbursement rated for travel by vehicle:
>
> - Ticket charge per person (one way or round trip) for inter-city bus transportation.
>
> - $.12 cents per mile for all **personal** vehicles if alternative transportation is not available and mileage reimbursement is necessary. This includes the client, relatives, friends, neighbors, etc.

- $.21 cents per mile only for:
    - Commercial non-emergency medical transport vehicles
    - Nonprofit agencies
    - Taxis
    - Vans operated by medical facilities or public entities such as health agencies
- $.265 per mile for registered volunteer services drivers and foster care parents

Do not authorize payment for "waiting time" or multiple trips for a single medical visit.

Program Administrative Manual (PAM), 825,
Effective 8-1-1999, Pages 8-9 of 16

The [redacted] vehicle rates were unchanged in the [redacted] update to the Medical Transportation policy, which remained in effect through the Appellant's death in [redacted]. Program Administrative Manual (PAM), 825, Effective 10-1-2001, Pages 9-10 of 16.

The Program Administrative Manual (PAM), 825 policy also addressed special allowances for payment for medical transportation. However, the policy strictly limited the special allowances to situations where the recipient's medical condition required the use of commercial non-emergency medical transportation vehicles specially equipped or designed to accommodate non-ambulatory (unable to walk) clients and prohibited special allowances for transport in a private vehicle or van. Program Administrative Manual (PAM), 825, as effective [redacted] through [redacted]

It was uncontested that the Appellant was reimbursed for medical transportation mileage at the rate for personal vehicles between [redacted] and [redacted]. It was also uncontested that the Appellant was transported in a personal vehicle by her daughter. The Appellant notes that in a [redacted] version of the Medical Transportation policy, the rates for personal vehicles and volunteers was equalized at [redacted]. Therefore, the Appellant asserts she should have been paid at the rate for volunteer service drivers retroactive to [redacted], rather than the personal vehicle rate, because the inequity of the situation is obvious and no volunteers were willing or able to provide the transportation. (Appellant's Closing Brief, pages 21-23)

The Delegation of Authority does not give this ALJ any equitable authority. This ALJ can only review the Department's determinations under the policy that was in effect at the time of the actions. Accordingly, a [redacted] policy revision equalizing reimbursement rate for personal vehicles and volunteer service drivers cannot be applied to services provided from [redacted] through [redacted]. The available Program Administrative Manual

(PAM), 825 policy, which was in effect from [redacted] through [redacted] is clear. The mileage reimbursement rate for personal vehicles was [redacted] per mile, and even special allowances could not be considered when a personal vehicle was used for the medical transportation. The Department's reimbursement of medical transportation mileage at the personal vehicle rate of [redacted] per mile from [redacted] through [redacted] is affirmed.

Home Help Services

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 Appellant is contesting the amount of her HHS authorizations from [redacted] through her death [redacted] (Appellant's Closing Brief, pages 5-21) Policy addressing the Home Help Services program is found in the Adult Services Manual (ASM), sections 361-365. The oldest version of this policy that could be found went into effect April 1, 1999 and states:

> **PROGRAM OVERVIEW**
>
> **PROGRAM DESCRIPTION**
>
> Independent Living Services (ILS) offer a range of payment and nonpayment related services to individuals who require advice or assistance to support effective functioning within a home or other independent living arrangement.
>
> Nonpayment independent living services are available, without regard to income or assets, upon request to any person who needs some form of in-home service.
>
> Home Help Services (HHS) are payment related unskilled non-specialized personal care service activities provided under ILS to persons who meet eligibility requirements.
>
> 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.
>
> Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living

- Eating
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living

- Taking Medication
- Meal Preparation/Cleanup
- Shopping/Errands
- Laundry
- Housework

Expanded Home Help Services (EHHS) can be authorized for individuals who have severe functional limitations which require such extensive care that the services cannot be purchased within the maximum monthly payment rate.

Adult Services Manual (ASM) 361, 4-1-1999,
Pages 1-2 of 3

Home Help Services (HHS)

Eligibility for HHS payments is based on:

Medicaid or Medical Aid Eligibility, **and**

Need for Service

- Client Needs Assessment (FIA-2620) indicating a functional limitation of level 3 or greater in at least one ADL or IADL, **and**

- Medical Needs (FIA-54A) signed and dated by a physician certifying a medical need for personal care services

Expanded Home Help Services (EHHS)

EHHS eligibility exists if **all** HHS eligibility criteria are met **and** the assessment indicates the client's needs are so

severe that the care needed cannot be met within the HHS monthly maximum payment.

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NOTIFICATION OF ELIGIBILITY DETERMINATION

Provide any person who applies for HHS with a written notice of approval, denial or withdrawal.

Services Approval Notice (FIA-1210)

If HHS are approved, complete and send a FIA-1210 indicating that personal care services will be authorized and the payment effective date.

Services Negative Action Notice (FIA-1211)

If HHS are denied or withdrawn, complete and send a FIA-1211 including the reason. The FIA-1211 informs the client of the right to request a hearing and explains the procedures for requesting a hearing.

REVIEW

Complete the Home Help Service Plan/Assessment Review (FIA-2624) every six months to update the assessment and the service plan. Review the adequacy of the service plan to assure it meets the client's current needs.

Review eligibility for HHS every 12 months, or sooner if the client's condition or circumstances warrant.

The annual review requires:

- MA eligibility verification,
- Client Needs Assessment,
- Home Help Service Plan

Adult Services Manual (ASM) 362, 4-1-1999,
Pages 1-3 of 3

Necessity For Service

The adult services worker has responsibility for determining the necessity and level of need for HHS based on:

- A complete assessment and determination of the client's need for personal care services.

- Verification of the client's medical need by a licensed physician.

Assessment

Determine the need for service with the client and/or the client's representative in a face-to-face interview in the client's home. Complete the Client Needs Assessment (FIA-2620) following instructions on the back of the form.

Physician's Certification of Need

If the client appears to need and be eligible for personal care services, request verification of a medical need for services from a physician using the Medical Needs form (FIA-54A). The client is responsible for obtaining the physician's certification of need.

The physician's role is to certify that the client's need for service is related to an existing medical condition. The physician does not prescribe or authorize home help personal care services.

***

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 needs cannot be met safely within the monthly maximum payment.

- The local office director/supervisory designee has approved the payment (EHHS $334 - $999) **or** Central office has approved the payment (EHHS over $1000).

All EHHS requests for approval must contain:

- Medical documentation of need, e.g., FIA-54A, **and**
- FIA-2620, FIA-4510 and FIA-2623 **and**

- Written plan of care which indicates:
  - How EHHS will meet the client's care needs **and**
  - How the payment amount was determined.

***

ASSESSMENT

Client Needs Assessment

Conduct a face-to-face interview with the client in the client's current living environment to thoroughly assess the need for HHS.

Assess the client's level of functioning, living environment and health and medical status during the interview. Record these on the Client Needs Assessment (FIA-2620). Any psychosocial impairments which affect functioning are recorded on the Comprehensive Assessment for Case Management (FIA-4510).

Functional Assessment

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 and Errands
Laundry
Housework

ADL and IADL 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.

4 - Much Human Assistance

Performs the activity with a great deal of human assistance.

5 - Dependent

Does not perform the activity even with human assistance.

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

Functional assessment definitions and ranks for each ADL and IADL can be found in SM Item 365, Appendix A.

Living Environment

Review the accessibility and/or availability of facilities and equipment in the client's current setting.

Medical and Health Status

Discuss the client's medical diagnosis and general health status.

List any medications the client is currently taking (prescription and nonprescription) and the prescribing physician(s) on the FIA-2620.

SERVICES PLANNING

Home Help Services Plan FIA-2623

Develop a service plan with the client and/or the client's representative. Document it on the Home Help Service Plan (FIA-2623).

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 (FIA-2620). 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: 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.

- 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).

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.

***

Services Not Covered By Home Help Services

Do **not** authorize HHS 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 - Medical transportation policy and procedures are in Services Manual Item 211.
- 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.

NURSING REVIEW

A registered nurse employed by Medical Services Administration (MSA) must review and approve the care plan for all persons receiving personal care services.

Send the FIA-2620, the FIA-2623 and a copy of the FIA-54A (openings only) for all case openings and annual reviews and the FIA-2624 for semiannual reviews by ID mail to:

Community Based Services
Health Services Review
Medical Services Administration

The RN will approve, disapprove or modify the service plan. Do not delay the payment authorization pending receipt of the RN's recommendation.

The RN is also available for case consultation upon request.

REDETERMINATIONS

Home Help Service Plan/Assessment Review (FIA-2624)

Use the Home Help Service Plan/Assessment Review (FIA-2624) to update the Client Needs Assessment (FIA-2620) and the Home Help Service Plan (FIA-2623) at six month intervals.

Conduct a face-to-face interview with the client at the time of the 6 months review and:

- Reassess the client's functional limitations.
- Review the adequacy of the service plan.
- Reassess the client/provider relationship
- Obtain the Provider Log (FIA-721).

Note: A face-to-face contact must occur at least three times in a six month period for case management methodology cases. A summary narrative to record contacts and adjustments to the service plan must be completed every six months.

Annual Review

Redetermine eligibility for HHS every 12 months in a face-to-face interview.

Complete the annual review to:

- Verify continued eligibility for Medicaid or Medical Aid.
- Complete a FIA-2620 to determine that a need for service continues.
- Complete a FIA-2623 and record how the client's service needs will be met.

Note: Complete a Comprehensive Case Management Reassessment (FIA-4511) at the annual review for case management methodology cases.

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Provider Log (FIA-721)

Each provider must keep a log of home help service provided. The Provider Log (FIA-721) is used for this purpose.

Indicate on the log which tasks the provider is approved to do based on the client's HHS plan.

The provider must indicate what services were provided and on which days of the month.

The client and the provider must sign the log when it is completed to verify that the services approved for payment were delivered.

The log must be submitted to the local office at least quarterly.

Initial and date the log upon receipt.

Retain the log in the client's case record.

A separate log is required for each provider.

Other types of logs such as billings for services are acceptable in lieu of the FIA-721. Each bill must specify the service provided and the date(s) of service.

PAYMENT AUTHORIZATION

Payment Authorization System

Enter home help provider enrollments and payment authorizations on the Model Payment System (MPS) using the Model Payment Authorization (FIA-2355).

No payment can be made unless the provider has been enrolled on the MPS provider database.

HHS payments to providers must be:

- Authorized for a specific type of service, period of time and payment amount.
- Authorized to the person actually providing the service.
- Made payable jointly to the client and the provider.

Any payment authorization that does **not** meet the above criteria must have the reason fully documented in the client's case record **and** requires the supervisor's signature on the case narrative and the FIA-2355.

Local Office Rate Schedule

Each local FIA office must maintain a rate schedule specifying the Department's determination of the going rate in the community for HHS.' The going rate reflects the cost of obtaining a HHS provider and is derived from information obtained from:

- Michigan Employment Security Commission,
- Local home care agencies,
- Individuals providing services,
- Adult services workers,
- Other available sources.

Provider transportation costs, working conditions and other related factors are considered in the development of the going rate.

A copy of the rate schedule must be furnished to each services worker and supervisor with responsibility for adult services programs.

The schedule must be updated annually.

Exception to the Department's Home Help Services Rate. Authorize an exception to the going rate if the individual circumstances justify an enhanced rate.

Reasons for an exception to the rate include, but are not limited to:

- The provider must possess specific skills or training to meet the client's needs.
- The client has severe mental and/or physical functional limitations.
- The client lives in an isolated area and lacks family support.

Payment Rates

HHS payments **cannot** exceed established maximum levels. **All** payments to the client are included within the maximum level, even if the client has more than one provider.

Service	Maximum Payment Levels
Home Help	$333 a month plus the client/employer's FICA allowance. Service Code 0301
Service Dog	$20 a month Service Code 0501
Home Help Services for Adults in Need of Protection	$666 plus the client/employer's FICA allowance within a 12 month period. Service Code 0302
Expanded Home Help Services	$334 - $999 a month plus the client/employer's FICA allowance with prior local office approval. Service Code 0301 $1000 and over a month plus the client/employer's FICA allowance with prior central office approval. Service Code 0301

Adult Services Manual (ASM) 363, 4-1-1999,
Pages 2-15 of 17

The Adult Services Manual policy regarding the HHS program remained substantially the same through the [redacted] update, which remained in effect through the time of the Appellant's death in [redacted] Adult Services Manual (ASM) 361-365, Effective 4-1-1999 through 10-1-2001).

The Appellant was authorized for HHS with a monthly care cost of [redacted] from [redacted] through [redacted] and a monthly care cost of [redacted] effective [redacted]. (Circuit Court Record, Tab 8, Services Approval notice dated [redacted] The HHS monthly care cost was increased to [redacted] on or about [redacted] (Circuit Court Record, Tab 8, Reasonable Time Schedule dated [redacted] The HHS monthly care cost was increased to [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval notice dated [redacted] The HHS monthly care cost was increased to [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval notice dated [redacted]) The HHS monthly care cost was increased to [redacted] effective [redacted]. (Circuit Court Record, Tab 8, Services Approval notice dated [redacted] and Memo dated [redacted] The HHS monthly care cost was increased to [redacted] effective [redacted] (Circuit Court Record, Tab 8, Services Approval notice dated [redacted] 2002) The monthly care cost of [redacted] included HHS hours for ADLs, IADLs, and the complex care activity of range of motion exercises. (Circuit Court Record, Tab 8, Michigan Department of Social Services Reasonable Time Schedule for Home Help Services dated [redacted] and Michigan Family Independence Agency Reasonable Time Schedule for Complex Care) Accordingly, the Appellant received HHS at the Expanded HHS payment level the majority of the time period at issue in this case.

The Appellant's daughter testified she does not feel she was adequately compensate for the care she provided to the Appellant and outlined the types of care she provided to the Appellant in Exhibit AA to the Appellant's prehearing brief. (Daughter Testimony) However, the HHS program is limited in what services are included and would not cover all the types of assistance the Appellant's daughter provided for the Appellant. As outlined in the above policy, HHS includes specific ADLs and IADLs. The HHS program also includes some complex care activities as discussed by the Program Manager and as evidenced in the Reasonable Time Schedule for Complex Care the HHS program. (Circuit Court Record, Tab 8, Michigan Family Independence Agency Reasonable Time Schedule for Complex Care; Testimony of Program Manager) HHS hours could not be authorized for several of the services the Appellant's daughter provided such as: taking the Appellant for haircuts four times per year; church, social, or other entertainment outings; reading to the Appellant; time spent accompanying to medical appointments; supervision with any activity; and never leaving the Appellant alone. (Appellant's Pre-Hearing Brief, Exhibit AA; Testimony of Daughter)

Regarding eating assistance, it is not clear what, if any, hands on assistance the Appellant's daughter is alleging she was providing with eating. It is only noted that the Appellant takes more time to eat because she did not have any natural teeth or dentures. (Appellant's Pre-Hearing Brief, Exhibit AA) No HHS hours could be authorized for eating if the assistance was only at a functional ranking of level 2, such as supervision while the Appellant ate. HHS hours can only be authorized for hands-on assistance, functional ranking 3 or greater.

The Appellant's daughter's statements regarding the amounts of time spent providing assistance that would be included in the HHS program cannot be found fully credible. For example, the typed outline indicates the Appellant's daughter provided eating assistance with all meals and snacks and toileting assistance [redacted] times per day as far back as [redacted]. (Appellant's Pre-Hearing Brief, Exhibit AA) The provider logs, signed by the Appellant and the Appellant's daughter from [redacted] through at least [redacted] do not indicate any assistance was provided with eating/feeding or toileting. (Circuit Court Record, Tab 8, Provider Logs dates [redacted] through [redacted] Additionally, the documentation from the Appellant's doctor dated [redacted] appears to be correcting an error with a [redacted] DSS-54A Medical Needs form, clarifying that the doctor did not certify a need for assistance with toileting, transferring and eating. Rather the doctor only indicated that Appellant needed assistance with bathing, dressing, meal preparation, laundry, food shopping/errands, medications and light house cleaning. (Circuit Court Record, Tab 8, [redacted] Doctors Instructions dated [redacted] and DSS 54A Medical Needs forms dated [redacted] and re-signed [redacted]

The amounts of time outlined by the Appellant's daughter for some activities, such as the total of [redacted] hours and [redacted] minutes daily, for meal preparation and clean up were excessive. (Appellant's pre-hearing brief, Exhibit AA) While it is understandable that the Appellant had dietary restrictions and no processed foods were used, it is not a reasonable assertion that it was medically necessary for meal preparation and cleanup to take close to [redacted] hours and [redacted] minutes every day. It appears at least part of this was cooking time, but the HHS program would not compensate for time spent waiting when no hands on services are being provided. For example, HHS would compensate for the time spent preparing food to getting it in the oven as well as the clean up after cooking, but not the time spent just waiting while food is roasting in the oven.

The Appellant contests the local office HHS provider rate and also asserts that an exception should have been granted in this case for the Appellant's daughter to be paid more. As discussed during the telephone hearing proceedings, there is no jurisdiction to review the hourly local office provider rate itself that was set by the Department. The local office rate schedule would have applied to all HHS providers in the county unless an exception was granted. The determination to not grant an exception in the Appellant's case is reviewable. However, as noted above, the outline of the care the Appellant's daughter provided cannot be found fully credible and did not describe unusual circumstances for a HHS case that would have provided justification for an enhanced rate.

While there is not documentation of every HHS case review and redetermination that should have been completed between [redacted] and [redacted] the evidence demonstrates that in general Department authorized increases in the Appellant's HHS total monthly care cost as her condition declined and her needs for assistance increased. The Appellant did not provide sufficient credible evidence to support additional HHS hours or an exception to the local office HHS provider rate for the Appellant. Accordingly, the Department's HHS authorizations from [redacted] through the Appellant's death [redacted] are affirmed.

Attorney's Fees and Costs

The Appellant's request for fees and costs must be denied. MCL 24.323 section 123 allows for costs and fees to be awarded to the prevailing party, other than an agency, when the presiding officer finds that the position of the agency was frivolous. The Appellant is not the prevailing party and the evidence does not support a determination that the Department's position was frivolous as outlined in MCL 24.323 section 123.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly authorized the Appellant's medical transportation reimbursement payments and properly authorized the Appellant's HHS payments.

IT IS THEREFORE ORDERED THAT:

The Department's decisions are AFFIRMED.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed [redacted]

Date Mailed: [redacted]

CL/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.