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. 2013-23870 HHS

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 provider, represented the Appellant. , the Appellant, appeared and testified. , Appeals Review Officer, represented the Department. Adult Services Worker ("ASW"), and Adult Services Supervisor, appeared as witnesses for the Department. The record was left open through for additional documentation from both parties, which has been received.

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. On the Appellant's doctor completed a DHS-54A Medical Needs form certifying that the Appellant had a medical need for assistance with the listed personal care activities of bathing, grooming, dressing, taking medications, meal preparation, shopping, laundry, and housework. (Exhibit 2, page 2)

2. The Appellant applied for HHS on (Exhibit 3, page 18)

3. An ASW completed an initial assessment and determined that the Appellant was potentially eligible for HHS with a total monthly care cost of . (Exhibit 1, page 14)

4. Department policy requires Medicaid eligibility in order to receive HHS, and clients with a monthly spend-down are not eligible until they have met their spend-down obligation. (Adult Services Manual (ASM) 105, , pages 1-2 of 3)

5. The Appellant had full Medicaid coverage with a scope/coverage code of 1F through . (Exhibit 1, page 7)

6. The Department authorized HHS from through The authorization for the partial month had a care cost of (Exhibit 1, page 13)

7. The Appellant's Medicaid status changed to having a monthly deductible, or spend-down, effective From through the Appellant's monthly spend-down was From through her monthly spend-down was Effective the Appellant's monthly spend-down went back to . (Exhibit 1, page 7; Exhibit 2, page 16)

8. The Appellant's Medicaid spend-down exceeds the total monthly care cost of HHS the Department determined she is potentially eligible for.

9. On the Department sent the Appellant an Advance Negative Action Notice which informed her that the HHS case would be terminated effective because she had not met her spend-down since (Exhibit 1, pages 8-11)

10. On the Appellant's Request for Hearing was received by the Michigan Administrative hearing System. (Exhibit 1, page 4)

11. The Appellant met her spend-down and was a full coverage Medicaid beneficiary, scope/coverage code 2F, for the months of and (Exhibit 1, page 7; Exhibit 2, page 16)

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) addresses eligibility for Home Help Services:

> **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 forms 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 IADL's 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 (ASM) 105,
11-1-2011, Pages 1-3 of 3

Adult Services Manual (ASM) 115, 11-1-11, addresses the DHS-54A Medical Needs form:

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 medical professional and not the client must complete the form. 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.

Adult Services Manual (ASM) 115, 11-1-2011, Pages 1-2 of 3

Adult Services Manual (ASM) 120, 5-1-12, addresses the comprehensive assessment:

INTRODUCTION

The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining need for services. The comprehensive assessment must be completed on **all open independent living services cases**. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information must be entered on the computer program.

Requirements

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.
- The assessment may also include an interview with the individual who will be providing home help services.
- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- 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.
    - Use the DHS-27, Authorization to Release Information, when requesting client information from another agency.

- Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation; see RFF 1555. The form is primarily used for APS cases.

▪ Follow rules of confidentiality when home help cases have companion APS cases, see SRM 131 Confidentiality.

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Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

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

Instrumental Activities of Daily Living (IADL)

- Taking Medication.
- Meal Preparation and Cleanup.
- Shopping.
- Laundry.
- Light Housework.

Functional Scale

ADLs and IADLs are assessed according to the following five-point scale:

1. Independent.
   Performs the activity safely with no human assistance.
2. Verbal Assistance.
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.
3. Some Human Assistance.
   Performs the activity with some direct physical assistance and/or assistive technology.
4. Much Human Assistance.
   Performs the activity with a great deal of human assistance and/or assistive technology.
5. Dependent.
   Does not perform the activity even with human assistance and/or assistive technology.

Home help payments may only be authorized for needs assessed at the 3 level ranking or greater.

An individual must be assessed with at least one activity of daily living in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADL's if the assessment 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 cut 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 instrumental activities of daily living 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 hours 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, 5-1-2012, Pages 1-4 of 5

Adult Services Manual (ASM) 101, 11-1-11, addresses services not covered by HHS:

> **Services not Covered by Home Help**
>
> Home help services must **not** be approved for the following:
>
> - Supervising, monitoring, reminding, guiding, teaching 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 (such as house cleaning, laundry or shopping).
> - Services provided by another resource at the same time (for example, hospitalization, MI-Choice Waiver).
> - Transportation - See Bridges Administrative Manual (BAM) 825 for medical transportation policy and procedures.
> - Money management such as power of attorney or representative payee.
> - Home delivered meals.
> - Adult or child day care.
> - Recreational activities. (For example, accompanying and/or transporting to the movies, sporting events etc.)
>
> **Note:** The above list is not all inclusive.

Adult Services Manual (ASM) 101, 11-1-2011, Pages 3-4 of 4.

On [redacted] the Department sent the Appellant notice that her HHS case would terminate effective [redacted] because she had not met her Medicaid spend-down, since [redacted] therefore she was no longer eligible for HHS. (Exhibit 1, pages 8-11)

Department policy requires a HHS participant to have full coverage Medicaid or have met the monthly Medicaid spend-down, in order to be eligible for the HHS program. At

the time the Advance Negative Action Notice was issued, the Appellant had not met her spend down, the scope/coverage code was still since the spend down went into effect Further, the Appellant's Medicaid spend-down of exceeded the total monthly care cost of HHS the ASW determined she is potentially eligible for, Accordingly, the Department determined the Appellant's HHS case must be terminated because she had not been eligible for HHS since (Exhibit 1, pages 7-11 and 14)

However, the evidence indicates the Appellant's spend down was met effective , which was prior to the effective date of the HHS termination. (Exhibit 1, pages 7-8) It is noted that this may have been a retroactive determination by the Medicaid eligibility specialist and this information may not have been available to the ASW when the Appellant's HHS case was closed in

Further, the Appellant contests the amount of HHS authorization the Department determined she was potentially eligible for. Because the ASW who completed the initial assessment of the Appellant's HHS application was not available for the telephone hearing proceedings and it ws not know if/when he would be available, the hearing record was left open for the Department to submit documentation from the ASW's initial assessment and for the Appellant provide any response. Based on a call from the Appellant that she had not received the additional documentation submitted by the Department, an extension was granted and the record was left open until so that the information to be re-sent to the Appellant and she would have an opportunity to respond.

It appears that the information utilized by the ASW for the initial assessment was a DHS-54A Medical needs form and an Adult Services Comprehensive Assessment form. (Exhibit 2, pages 2-8) The typed Adult Services Comprehensive Assessment form does not appear to be from the ASW's initial assessment. Rather, it appears to have been created on the date of the telephone hearing proceedings. As such the Adult Services Comprehensive Assessment cannot be considered as evidence of the ASW's initial assessment. (Exhibit 2, pages 9-15) The Appellant's response began with a copy of all of the additional documentation from the Department. (Exhibit 3, pages 1-17) The Appellant's actual response included a timeline and additional correspondence from the Department. (Exhibit 3, pages 18-22)

The Appellant's provider focused on the ASW's behavior; including not informing the Appellant of the Medicaid spend down status and delays in making a determination on the HHS application. (Exhibit 3, pages 18-19) However, this ALJ does not have any jurisdiction over the Medicaid spend down determination nor any equitable authority to grant any relief based on unprofessionalism of an ASW or delays in processing a case and communicating with a HHS applicant.

This ALJ can only review the Department's determinations relating to the HHS case, including the amount of HHS she was potentially eligible for and the decision to terminate the HHS case due to having an unmet Medicaid spend down, but not the Medicaid spend down status itself.

As discussed above, there evidence establishes that the Appellant's spend down was met, scope/coverage code 2F, prior to the termination date. Specifically the Appellant's spend down was met for the month of Further, the Appellant met her spend down again for the month of (Exhibit 1, page 7; Exhibit 2, page 16) Accordingly, the termination based on having an un-met spend down cannot be upheld.

Regarding the HHS authorization amount, the ASW determined the Appellant was potentially eligible for HHS with a total monthly care cost of . This included assistance with bathing, dressing, transferring, medication, housework, laundry, shopping and meal preparation. (Exhibit 1, page 14)

The available evidence from the ASW's initial assessment is insufficient to properly review the determination. The ASW did not document his functional ranking determinations nor much detail of the discussion regarding the Appellant's functional abilities and needs for assistance with ADLs and IADLs that should have occurred during the home visit. The Appellant's doctor certified that the Appellant has a medical need for assistance with personal care activities, specifically bathing, grooming, dressing, taking medications, meal preparation, shopping, laundry, and housework. (Exhibit 2, page 2) The Appellant's testimony indicates assistance with ADLs like bathing is provided daily, rather than the three days per week authorized by the ASW. (Appellant Testimony) Further, it is not clear why the ASW would have authorized so few HHS hours for IADLs like laundry and shopping. (Exhibit 1, page 14)

Accordingly, the Appellant's HHS case shall be reinstated and a new assessment is needed to determine an appropriate monthly HHS authorization. Further, the Department may authorize HHS for any time periods the Appellant met her Medicaid spend down and can establish that the services included in the HHS authorization were provided through the enrolled agency provider.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly terminated the Appellant's HHS case.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department shall re-instate the Appellant's HHS case, complete a new assessment and may authorize HHS for any time periods the Appellant met her Medicaid spend down and can establish that the services included in the HHS authorization were provided through the enrolled agency provider.

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

Date Signed:

Date Mailed:

CL/db

cc:

***** 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.