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:

[redacted],

Docket No. 2013-15259 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 appeared without representation. She had no witnesses. [redacted], Appeals Review Officer, represented the Department. His witness was [redacted], ASW.

ISSUE

Did the Department properly assess the Appellant for her receipt of Home Help Services (HHS)?

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 disabled [redacted]-year-old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant alleges disability by way of HTN, "serious" COPD, heel spurs and stroke. (Department's Exhibit A, pp. 9 and 10)

3. On in-home assessment conducted on [redacted] the ASW (Andrea White) determined that the Appellant needed assistance with the ADLs/IADLs of bathing, mobility, medication, laundry, shopping and meal preparation. She assessed the Appellant for HHS in the amount of 49:35 hours per month at a total cost of: [redacted]. (Department's Exhibit A, pp. 9 and 12)

4. The Appellant does not appeal the assessment. (Appellant's Exhibit #1)

5. The Appellant said she applied for HHS services in [redacted], following all of the State of Michigan website prompts and instructions to contact her DHS caseworker [redacted]. (*See* Testimony)

6. She kept track of communications by fax to the Department submitting and resubmitting required application documents on [redacted], [redacted] and [redacted]. (*See* Joint Exhibit #2 and Testimony of Dickson)

7. Finally, in [redacted] she was told that additional information was needed by way of a DHS 54A Medical Needs form – which the Appellant said could have been provided in January had she been notified sooner.[1]

8. The Appellant also tracked the progress with regard to required threshold application form DHS 390 - documenting that it was sent to her caseworker [redacted] and [redacted] County DHS on (3) three occasions. (Department's Exhibit B, p. 4 and Joint Exhibit #2, pp. 1 – 5)

9. The Appellant testified that she was merely following departmental web-site based instructions in sending her forms to [redacted] and that while waiting for the Department to respond she was not alarmed - because her recent Medicaid disability status "took over 9-months to process." (*See* Testimony of [redacted])

10. The Department witness testified that the award and payment of HHS was made retroactive to [redacted] – the execution date by the Appellant's physican. (*See* Testimony of White and Department's Exhibit B, p. 5)

11. On [redacted] the ASW sent the Appellant a DHS1210a – Services and Approval Notice advising her that HHS services would issue with an effective date of [redacted] - including a partial payment for [redacted] through [redacted] of $[redacted] net. (Department's Exhibit A, p. 5)

12. The request for hearing on the instant appeal was received by the Michigan Administrative Hearings System (MAHS) for the Department of Community Health on [redacted] (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

COMPREHENSIVE ASSESSMENT

[1] On review, the rankings assigned to the level of the Appellant's affliction and disability were not in dispute. *See* Department's Ex. A, at page 9 and Department's Ex. B at page 5.

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 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.

….

Adult Service Manual (ASM), §120, page 1 of 6, 11-1-2011.

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 Service Requirements.

ASM §105, page 2 of 3, November 1, 2011

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ADULT SERVICES REQUIREMENTS - 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.

….

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 <u>not</u> 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.

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> 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. (Emphasis supplied by ALJ) ASM 115, pages 1 and 2 of 3, *Supra*

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The Department witness testified that a services approval notice was sent to the Appellant on [redacted] approving HHS in the amount of $[redacted] per month total cost of care. There was no dispute in the record concerning necessity for service that the Appellant was both disabled and in need of HHS by way of ADLs and IADLs. There was also no dispute by the Appellant that the Department provides her a vital service – for which she is grateful. She said she knew the Department was busy. The approval notice contained referenced retro active payment – including a partial retro active payment for the month of [redacted][2] in the amount of $[redacted]

The Appellant appeals – not to contest the total cost of care or hours determined by the ASW, but rather to contest the 10-month delay in processing her application. In support the Appellant provided documentation [she kept records] of her contact with the Department's website, its instruction, her subsequent contact with [redacted] DHS employee and her several services of required documentation as directed by the Department – but without apparent follow-up. The Appellant testified that she wasn't too alarmed because she had experienced a 9 month delay in obtaining her Medicaid disability rating from DHS – but when several months had passed she dug deeper and found that no action had been taken on her application and now the department required timed documents which she could have easily provided in [redacted] – had they told her.

Interestingly, the Appellant's time stamped application shows execution of Application DHS 390 on [redacted] and receipt by the DHS Oakman branch on [redacted]. (See Department's Exhibit B, page 2, and Joint Exhibit #2 – throughout) The Department witness explained that they are prohibited by policy from approving HHS sooner than the date of execution by the Medicaid enrolled medical professional – which took place on [redacted].[3]

On review, the Appellant seeks retroactive reimbursement for her chore provider – beyond the 3-month limitation established under policy as she credibly demonstrated the delay[4] was interposed by the Department – not her.

[2] From the date of execution by the Medicaid enrolled medical professional.
[3] While an accurate explanation of policy the DHS 54A Medical Needs form was not mailed out to the Appellant until [redacted]. *See* Testimony of ASW White.
[4] ALJ Note: No implication of dishonesty was advanced by the Appellant.

By design and delegation of authority the ALJ, in these administrative cases, has limited equitable jurisdiction – a remedy perhaps available in judicial courts of general jurisdiction.[5]

The Department's role is that of honest broker and to act as an advocate by informing the client on how to make the best possible use of available resources. *See* ASM 100 and 102.[6] Unfortunately, the Department rubs up against fundamental due process prohibitions by the imposition of unaccountable delay in processing the Appellant's application – *however justified* – by case loads and process.[7]

On review, based on the testimony of the ASW, I find that she comprehensively assessed the Appellant and her need for HHS was appropriately established with a total cost care at $[redacted] for 49 hours and 35 minutes of service per month.

While the assessment of the ASW is controlled by policy and is afforded great weight by the ALJ – the broader systemic delay issue argued by the Appellant calls for an equitable or administrative resolution beyond the ALJ's jurisdiction.

The Appellant has not preponderated her burden of proof to establish that the Department erred in its assessment.

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[5] The Bridges Administrative Manual (BAM) also provides a process for generalized complaint:

General Complaints All Programs
Clients have the right to make general complaints about matters other than the right to apply, nondiscrimination or hearing issues. Written complaints can be sent to:

Michigan Department of Human Services
Specialized Action Center
235 S. Grand Avenue
PO Box 30037
Lansing, MI 48909

That office also responds to complaints via telephone: 517-373-0707. …BAM 105, page 4. 11-1-2012

[6] The mission statement is broadly worded: …[T]o accomplish this vision, DHS will:
● Act as resource brokers for clients.
● Advocate for equal access to available resources.
● Develop and maintain fully functioning partnerships that educate and effectively allocate limited resources on be half of our clients. (ASM 100 page 1 of 2) … 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 best possible use of available resources…
(ASM 102)

[7] "Legal security for the class of welfare claimants lies, not in hearings, but in good management…" discussing the "irrational" implications [of*] "…that seem to attend bureaucratic implementation of general rules." J. Mashaw, Due Process in the Administrative State 35-36 (1985) **Goldberg v. Kelly*, 397 US 254, 269 (1970)

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly established HHS for the Appellant on [redacted], retroactive to [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

\s\
Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/19/2013

***** 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.