

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████,

Appellant.

Docket No. 2013-37883 HHS¹

Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Appeals Review Officer, represented the Department of Community Health. ██████████, Adult Services Worker (ASW), and ██████████, from ██████████ County DHS testified as witnesses for the Department.

ISSUE

Did the Department properly decide not to re-authorize Appellant's 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. Appellant is a ██████ year-old Medicaid beneficiary who has been diagnosed with bipolar disorder, manic depression, osteoarthritis, and lumbar myositis. Appellant also reports pancreatitis and a history of strokes. (Respondent's Exhibit A, page 9).
2. Appellant has received HHS through the Department, with a total monthly care cost of \$██████ per month. Specifically, Appellant was authorized for assistance with bathing, taking medication, housework, laundry, shopping, and meal preparation. (Respondent's Exhibit A, pages 10-11).
3. In a letter dated ██████████, ASW ██████████ sent Appellant notice of an upcoming home visit and redetermination on ██████████. ASW ██████████ also testified that he sent an accompanying letter stating that

¹ This matter was originally miscoded as an HHP in the belief that Appellant was a Home Help Provider. However, it became clear during the hearing that Appellant is the beneficiary of Home Help Services (HHS) and it is her services that are the subject of this appeal.

Appellant's provider had to be present for the visit as well. (Respondent's Exhibit A, page 6; Testimony of ██████████).

4. On ██████████, ASW ██████████ conducted a home visit and reassessment of Appellant's services. Appellant was present for that visit, but her provider was not. (Respondent's Exhibit A, page 7).
5. Given that the provider was not present, ASW ██████████ was unable to complete the redetermination. He did inform Appellant that he needed to speak the provider in person in order to complete the redetermination and reauthorize services. (Testimony of ASW ██████████).
6. According to Appellant, she and her provider came to the local DHS in ██████████ and spoke with ASW ██████████. ASW ██████████ testified that no such meeting occurred. (Testimony of Appellant; Testimony of ASW ██████████).
7. According to the Department's witnesses, an arrangement was made for Appellant and her provider to come into the DHS office in ██████████, but they failed to appear. (Testimony of ASW ██████████; Testimony of ██████████).
8. Appellant's case remains open, but, given that ASW ██████████ was unable to complete the annual redetermination or reauthorize services, no new authorization was approved. Appellant's HHS payments therefore stopped after the prior authorization of services expired. (Respondent's Exhibit A, pages 11, 13; Testimony of ASW ██████████; Testimony of ██████████).
9. On ██████████, the Michigan Administrative Hearing System (MAHS) received a Request for Hearing in this matter. (Respondent's Exhibit A, pages 4-5).
10. Appellant does not currently have a HHS provider because her former provider quit after payments stopped. (Testimony of Appellant).

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.

Adult Services Manual 101 (11-1-2011) (hereinafter "ASM 101") and Adult Services Manual 120 (5-1-2012) (hereinafter "ASM 120") address the issues of what services are included in Home Help Services and how such services are assessed. For example, ASM 101 provides:

Home Help Payment Services

Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.

Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.

Home help services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care facility (ICF) for persons with developmental disabilities or institution for mental illness.

These activities must be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. **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.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)

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

Instrumental Activities of Daily Living (IADL)

- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Housework.

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. [ASM 101, pages 1-2 of 4 (italics added).]

ASM 120 states:

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.

Home Help 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 IADL's if the assessment determines 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. [ASM 120, pages 2-3 of 5.]

Moreover, with respect to the review of HHS once they are already granted, Adult Services Manual 155 (11-1-2011) provides:

CASE REVIEWS

Independent living services (home help) cases must be reviewed every six months. A face-to-face contact is required with the client, in the home.

A face-to-face or phone contact must be made with the provider at six month review and 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.

Six Month Review

Requirements

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- Verification of the client's Medicaid eligibility, when home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan, if applicable.
- Review of client satisfaction with the delivery of planned services.

- Reevaluation of the level of care to assure there are no duplication of services.
- Contact must be made with the care provider, either by phone or face-to-face, to verify services are being provided.

Documentation

Case documentation for **all** reviews must include:

- An update of the “**Disposition**” module in ASCAP.
- A review of **all** ASCAP modules with information updated as needed.
- A brief statement of the nature of the contact and who was present in the **Contact Details** module of ASCAP. A face-to-face contact entry with the client generates a case management billing.
- Documented contact with the home help provider.
- Expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- A record summary of progress in service plan.

Annual Redetermination

Procedures and case documentation for the annual review are the same as the six month review, with the following addition(s):

- A new DHS-54A certification, if home help services are being paid.

Note: The medical needs form for SSI recipients and Disabled Adult Children (DAC) is only required at the initial opening and is not required for the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and annually thereafter.

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- Contact must be made with the care provider, either by phone or face-to-face, to verify services are being provided.

According to the above policy, the ASW must have face-to-face contact with a care provider at least once a year. Here, as testified to by the Department's witnesses, if Appellant's care provider was not seen face-to-face prior to any reauthorization of services in this case, then it would be over 18 months between face-to-face visits. Such a time period would be in violation of policy. ASW ██████████ therefore properly found that Appellant's provider had to be seen face-to-face prior to any reauthorization of HHS.

The dispute in this case involves whether Appellant's provider did make himself available for a face-to-face contact. According to Appellant, she was never informed that the provider had to be present for the home visit and that, after she was so informed; she and her provider went to the local DHS office and spoke with ASW ██████████. On the other hand, ASW ██████████ testified that he sent a letter stating that Appellant's provider had to be present for the home visit and that he never met with any provider to complete the redetermination. The Department's witnesses also testified that Appellant and her provider never came into the local DHS office for a face-to-face meeting, even when a meeting was scheduled in ██████████.

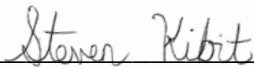
Appellant bears the burden of proving by a preponderance of the evidence that the Department in erred in not re-authorizing her HHS. Here, Appellant's former authorization for HHS has expired and, in order to re-authorize services, the Department had to meet with her care provider face-to-face. This Administrative Law Judge finds the Department's witnesses to be credible in their testimony that no such meeting ever took place and that the provider never met with ASW ██████████, or any other DHS worker, face-to-face. Accordingly, this Administrative Law Judge also finds that the Department properly determined that services could not be reauthorized without such a meeting and Appellant's HHS payments stopped after the previous authorization expired. Appellant's case is still open and, as indicated by the Department's witnesses, she may still be eligible for HHS. However, in order to receive such services, an enrolled provider would have to meet with her ASW face-to-face.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly decided not to re-authorize Appellant's Home Help Services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.



Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
Date Signed: 6/24/2013

Date Mailed: 6/24/2013

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.