

**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:**

████████████████████,

Appellant.

**Docket No.** 2014-15972 HHS

██████████

██████████

**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 ██████████ ██████████ ██████████ appeared on Appellant's behalf. Appellant also testified on her own behalf. ██████████ ██████████ Appeals Review Officer, represented the Department of Community Health. ██████████ ██████████, Adult Services Supervisor, testified as a witness for the Department.

**ISSUE**

Did the Department properly deny Appellant's request for 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 a traumatic brain injury. (Petitioner's Exhibit 2, page 1; Petitioner's Exhibit 3, page 1).
2. On ██████████, Appellant was referred for HHS. (Petitioner's Exhibit 5, page 1; Respondent's Exhibit A, page 9).
3. As part of the application process, Appellant submitted a medical needs form signed by her doctor on ██████████. (Petitioner's Exhibit 3, page 1).

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<sup>1</sup> A telephone hearing was previously scheduled for ██████████, but the matter had to be adjourned and rescheduled after Appellant requested an in person hearing.

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4. In that form, Appellant's doctor certified that Appellant had a medical need for assistance with the tasks of toileting, bathing, taking medications, meal preparation, shopping, laundry, and housework. (Petitioner's Exhibit 3, page 1).
5. At the time of the referral, the Department's records indicated that Appellant had a Medicaid deductible, or spend-down, of ██████████ per month and a scope of coverage of ██████. (Respondent's Exhibit A, page 10).
6. Appellant acknowledges that she had a deductible at that time, but also had documentation stating it was only ██████████ per month. (Petitioner's Exhibit 6, page 1).
7. No assessment was ever performed in Appellant's home. (Respondent's Exhibit A, pages 1-27; Testimony of Appellant).
8. Appellant and a friend did briefly meet with Adult Services Worker (ASW) ██████████ on ██████████, in the lobby of the ██████████ County Department of Human Services (DHS). (Testimony of Appellant).
9. During that meeting, ASW ██████████ indicated that she had not yet looked over Appellant's information, but that she would do so and set up an assessment on a later date. (Testimony of Appellant).
10. ASW ██████████ also indicated that she was retiring soon. (Testimony of Appellant).
11. An Adult Services Comprehensive Assessment Form dated ██████████ was put in Appellant's file, but that form was blank except for the customer identification. (Petitioner's Exhibit 2, pages 1-7).
12. On ██████████, ASW ██████████ wrote in Appellant's file that she planned to deny the application on the basis that, due to the size of Appellant's spend-down and the amount of supervision that Appellant is in need of, the parameters of the program will not permit her to be serviced. (Respondent's Exhibit A, page 9).
13. On ██████████, the Department sent written notice to Appellant indicating that her application for HHS was being denied. (Respondent's Exhibit A, pages 5-6).
14. With respect to the reason for the denial, the notice stated: "DUE TO THE LIMITED PARAMETERS OF THE HOME HELP PROGRAM, THE PROGRAM WILL NOT PAY FOR PROMPTING OR SUPERVISION." (Respondent's Exhibit A, page 6).
15. ASW ██████████ subsequently retired. (Testimony of Cusik-Spencer).

16. On ████████████████████ the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Appellant with respect to the denial of HHS. (Respondent's Exhibit A, page 4).

### **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 (5-1-2013) (hereinafter "ASM 101") and Adult Services Manual 120 (5-1-2013) (hereinafter "ASM 120") addressed the issues of what services are included in Home Help Services and how such services were assessed at the time of the negative action in this case. 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.

\* \* \*

**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.

*ASM 101, pages 1-2, 4-5 of 5*

Moreover, ASM 120 states:

## **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.

\* \* \*

### **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 1-3 of 7*

Here, the Department's notice stated that it was denying Appellant's application on the basis that the Home Help Program does not pay for prompting or supervision. (Respondent's Exhibit A, page 6).

However, while it is true that HHS must not be approved for "[s]upervising, monitoring, reminding, guiding, teaching or encouraging", ASM 101, page 4 of 5, the basis for ASW ██████████ conclusions regarding Appellant's needs are absent in this case as no functional assessment was ever completed in Appellant's home as required by the above policy. Appellant and ASW ██████████ only met once, in the DHS lobby, and the

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assessment form generated after that meeting was left blank except for the customer identification. (Petitioner's Exhibit 2, pages 1-7; Testimony of Appellant). Moreover, Appellant's file contains no notes, rankings, or explanations from ASW [REDACTED] (Testimony of [REDACTED]). Appellant also credibly testified that ASW [REDACTED] only indicated that she had not yet looked over Appellant's information, but that she would do so and set up an assessment at a later date, which she never did. (Testimony of Appellant).

With respect to Appellant's needs, Appellant's doctor certified that Appellant had a medical need for assistance with a number of ADLs and IADLs while Appellant credibly testified that, in addition to supervision and prompting, she also needs direct physical assistance with those tasks. (Petitioner's Exhibit 3, page 1; Testimony of Appellant).

That testimony is essentially unchallenged as ASW [REDACTED] did not testify and she left no documentation or notes regarding her findings. Accordingly, this Administrative Law Judge finds that Appellant has met her burden of proving by a preponderance of the evidence that the Department erred in denying her application for HHS on the basis that she only required supervision and prompting assistance.

Additionally, while it was not part of the notice of denial, ASW [REDACTED] did note that Appellant had a spend-down and the Department now argues that the denial should be affirmed on that basis. However, as no assessment was ever performed, this Administrative Law Judge also rejects that argument.

With respect to eligibility for HHS and spend-downs, Adult Services Manual 105 (5-1-2013) (hereinafter "ASM 105") states:

**GENERAL**

Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened to supportive services to assist the client in applying for Medicaid.

Home help services payments cannot be authorized prior to establishing Medicaid eligibility and a face-to-face assessment completed with the client. Once MA eligibility has been established, the case service methodology must be changed to case management.

**Requirements**

Home help eligibility requirements include all of the following:

- Medicaid eligibility.

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

### **Medicaid/Medical Aid (MA)**

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

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

The client must have a scope of coverage of either:

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

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

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

### **Medicaid Personal Care Option**

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and coordinate implementation with the eligibility specialist.

Conditions of eligibility:

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

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

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

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

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

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

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

*ASM 105, pages 1-2 of 4*

Here, the Department correctly notes that, at the time of the negative action in this case, the Department's records indicated that Appellant had a Medicaid deductible of ██████████ per month and a scope of coverage of ██████ (Respondent's Exhibit A, page 10). Given that scope of coverage, it does not appear that Appellant is eligible for HHS.

However, Appellant and her representative argue that, given her needs, Appellant could qualify for the Medicaid Personal Care Option discussed in the above policy and therefore still been approved for HHS despite her spend-down.

This Administrative Law Judge finds it unlikely that the cost of Appellant's personal care services would be more than her Medicaid excess income amount or that she would qualify for the Medicaid Care Option. Nevertheless, it is impossible to uphold the Department's decision on that basis given the complete failure to assess Appellant in this case and the absence of any specific findings regarding Appellant's needs. Appellant may not be entitled to HHS, but she is entitled to a functional assessment and the Department's decision to deny her request for services must be reversed.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly denied Appellant's request for HHS.

**IT IS THEREFORE ORDERED THAT:**

The Department's decision is **REVERSED** and it must initiate a reassessment of Appellant's application for HHS.

*Steven Kibit*

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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.