STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted],

Docket No. 2014-7311 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 and offered testimony. [redacted], Appeals Review Officer, represented the Department of Community Health (Department). [redacted], Adult Services Worker (ASW), appeared as a witness for the Department.

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. As of [redacted], the Appellant received HHS based upon a need for assistance with Instrumental Activities of Daily Living (IADL's) as well as a need for assistance with bathing. (Exhibit A, pp. 8, 10; Testimony)

2. On or around [redacted], the ASW reviewed the returned provider logs. The provider logs covered the time period of [redacted] through [redacted]. (Exhibit A, pp. 11-16; Testimony)

3. From [redacted] through [redacted], the Appellant's provider assisted the Appellant with bathing a total of 3 times. The provider did not assist the Appellant with bathing the whole months of [redacted], [redacted], [redacted], [redacted], [redacted] or [redacted]. (Exhibit A, pp. 11-16)

4. On [redacted], the Department sent the Appellant an Advance Negative Action Notice. The notice indicated the Department was closing the Appellant's HHS case. (Exhibit A, p. 5; Testimony)

5. On [redacted], the Michigan Administrative Hearings System (MAHS) received a request for hearing from the Appellant. (Exhibit A, p. 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.

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 (ASM) 101, 11-1-11, addresses HHS payments:

> **Payment Services Home Help**
>
> 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.
>
> *ASM 101,*
> *12-1-2013, Page 2 of 5.*

ASM 105, 12-1-2013, addresses HHS eligibility requirements:

> **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.

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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.

Adult Services Manual (ASM) 105,
12-01-2013, Pages 1-3 of 3

ASM 120, 12-1-2013, pages 1-4 of 5 addresses the adult services 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 will 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 IADLs 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.

ASM 120, 12-1-2013,
Pages 1-5 of 5

ASM 135, 12-1-2013, pages 1-9 address provider selection as well as provider logs:

Provider Selection

The client has the right to choose the home help provider(s). As the employer of the provider, the client has the right to hire and fire providers to meet individual personal care service needs. Home Help Services is a benefit to the client and earnings for the provider.

Personal Care Services Provider Log

- Each individual provider must keep a log of home help services delivered. The DHS- 721 is used for this purpose.

- Tasks on the provider logs are automatically marked with an X when printed from ASCAP based on the client's home help functional assessment.

- **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 quarterly. Provider logs must be received within 10 business days after the last service date on the log. Failure to do so will result in suspension of payment.

- The adult services specialist must initial and date the log upon receipt, demonstrating review of the log.

- Retain the log in the client's case record.

- A separate log is required for each provider.

- Incomplete logs must be returned to the client/provider for completion.

ASM 135, 12-1-2013,
Pages 1-9 of 9

* * *

The exhibits reflect the Appellant had been receiving HHS based upon a need for assistance with IADL's as well as a need for assistance with bathing. The policy reflects assistance with an ADL in order to be eligible for HHS. The exhibits also reflect that from [redacted] through [redacted], the Appellant very rarely received assistance with bathing. The ASW testified that based upon the completed logs, there was no longer a need for assistance with an ADL as the provider was not providing assistance with the lone ADL that was in existence at the time HHS was approved.

At the hearing, the Appellant testified that her providers were not properly filling out the logs and that she is in need of assistance. The Appellant however has the responsibility of reviewing the log sheets and verifying that they are filled out correctly. On 8 of the 9 logs, the Appellant had affixed her signature to the logs verifying they were completed correctly.

Based on the evidence presented, Appellant has failed to prove, by a preponderance of evidence, that the termination of HHS was inappropriate. As such, the evidence was not sufficient to establish that Appellant had a need for hands on assistance, functional ranking 3 or greater, with at least one ADL, based on the information available to the ASW when they terminated the Appellant's HHS case. Accordingly, the HHS termination is upheld.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

\s_____
Corey A. Arendt
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: December 11, 2013

Date Mailed: December 11, 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 March 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.