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. 14-012493 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]. Appellant's payee and parent [redacted] appeared on behalf of Appellant at the time and place for the scheduled administrative hearing but due to what was documented as a failure to initiate the hearing by both the local office and MAHS, the hearing was adjourned. On [redacted] the Michigan Administrative Hearing System (MAHS) rescheduled the hearing for [redacted] at [redacted]

At the time and place of the rescheduled hearing, MAHS was unable to reach the Adult Services Worker (ASW), and unable to reach the assigned Adult Services Supervisor (ASS). At [redacted] the Hearings Coordinator informed MAHS that Appellant had shown for the hearing, and that the Department was on its way to the hearing room. At [redacted], a stand-in ASS who did not have personal knowledge of the case contacted MAHS and stated that the ASS and the ASW who were assigned to the case were not available, without explanation. The Department Appeals Review Officer (ARO) requested an adjournment. The adjournment was denied on the grounds that good cause was not shown.

Appellant's parent, [redacted] appeared on behalf of Appellant. [redacted], ARO represented the Department. [redacted], ASS, substituted and appeared on behalf of the Department as a witness.

ISSUE

Did the Department properly deny Appellant's Home Help Services ("HHS") application?

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 [redacted] year old male who is a Medicaid beneficiary, administered by the Michigan Department of Human Services. Appellant is on a G2SM Medicaid case with a $ [redacted] spend-down effective [redacted], scope 2C. (Exhibit A.13).

2. Appellant diagnosis is autism and diabetes. (Exhibit A.12 & 19). A psychological assessment indicates Appellant's functioning for communication is 1 year old; daily living 5 years; and socialization 1 year. Adaptive behavior is listed as sever profound deficit. (Exhibit A. 5-9).

3. On [redacted] the ASW conducted an initial in-home assessment pursuant to a referral for the Home Help Services Program (HSS). The ASW did not determine that Appellant had any hands-on needs assistance. (Exhibit A.19).

4. A DHS-54A completed by Appellant's physician states that Appellant needs assistance with all ADLs and IADLS. (Exhibit B.1)

5. On [redacted] the Department issued a Denial Notice for Appellant's HHS application informing Appellant that he did not meet the minimum qualification for the HHS program due to a new policy requiring hands on assistance in at least one ADL category effective [redacted]. (Exhibit A.15).

6. On [redacted] the Appellant's Request for Hearing was received by the Michigan Administrative hearing System. (Exhibit A.4).

7. The Department argues in the alternative that Appellant would not have eligibility due to his spend-down not being met. (Exhibit A.2).

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:

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, November 1, 2011, pages 1-2 of 3).

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.
>
> *Adult Services Manual (ASM) 105, 11-1-2011 pages 1-2 of 3*

Other general HHS policy and procedure states in part:

> 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.
>
> *Adult Services Manual (ASM) 101, 11-1-2011, Page 1of 4.*

Adult Services Manual (ASM) 105, 11-1-11, 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,
11-1-2011, Pages 1-3 of 3

Adult Services Manual (ASM 120, 5-1-2012), 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.

Adult Services Manual (ASM) 120, 5-1-2012,
Pages 1-5 of 5

At an administrative hearing, Appellant bears the burden of proof to establish eligibility.

In this case, Appellant's guardian argues that Appellant needs hands on assistance. The Department's denial indicates that Appellant does not have any hand-on assistance and due to a new policy, there is no eligibility.

First, this ALJ notes that the "new" policy the Department refers to was put into effect in [redacted]. It is hardly new. What is relevant is that ASM policy requires a showing of a need for an ADL in order for the Department to open an HHS case.

For an individual such as Appellant, who has a severe mental impairment, this may be very difficult to show. While policy recognizes a mental impairment as a medical condition that will allow an individual to be eligible to have an HHS case, still, that individual must meet the program requirements. The program requirements are measured by a functional or exertional limitation, which often cannot capture limitations of a severe cognitive impairment.

As noted above, the individuals who had personal knowledge of this case failed to appear at the administrative hearing for testimony and/or cross-examination, without cause. Specifically, here, Appellant's guardian raised credible facts. However, the ASW who was absent could not give testimony, be questioned, and/or cross-examined. Under general evidentiary rules, an ALJ would be required to reverse the Department. However, here, the Department makes an alternative argument having to do with eligibility-the Department argues that Appellant would not be otherwise eligibility as he has a spend-down that was not met. As noted in ASM 105 above, in order for an individual to have eligibility for the HHS who has a spend-down, the spend-down must first be met. There is no evidence to show that Appellant has or has been meeting his spend-down month-to-month. (Exhibit A.13)

Appellant's representative argued at the administrative hearing that Appellant does not have a spend-down, and has SSI. However, the evidence submitted by the Department clearly shows Appellant as having aG2SM with a spend-down of $ [redacted] per month. See Exhibit A.13. It may be that Appellant has confused the SSI program with RSDI. Appellant's representative had no evidence that Appellant did not have a spend-down. The reports submitted in the evidentiary packet are clear. (Exhibit A.13).

This ALJ must make a determination based on the evidence of record. As the evidence of record supports finding that Appellant has no eligibility as long as he has a spend-down, the determination of ADLs which could not be credibly examined without the Department's witness is not relevant. This ALJ must uphold the denial based on the Department's alternative argument-Appellant does not have eligibility for the HHS program when he is not meeting his monthly spend-down.

It is noted that Appellant might be eligible for the waiver program. It is also noted that Appellant may find some assistance from the CMH programs in his community. It is further noted that Appellant should check with his DHS eligibility worker regarding his Medicaid classification if he believes that the Social Security interface is reporting incorrect information. It is further noted that if Appellant is an adult disabled child (DAC), he might be eligible to have his income cap adjusted for his Medicaid benefits, which is something that his DHS eligibility worker for his Medicaid would need to assess as it cannot be reviewed at a DCH hearing.

As this case stands, based on the evidence of record, this ALJ must uphold the denial.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's HHS application.

IT IS THEREFORE ORDERED that:

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

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

JS/[redacted]

cc: [redacted]

Date Signed: [redacted]

Date Mailed: [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.