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. 14-016023 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 Appellant's request for a hearing.

After due notice, a telephone conference hearing was held on [redacted]. Appellant personally appeared and testified. [redacted], [redacted], represented Appellant at the administrative hearing.

[redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Supervisor (ASS) appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly begin payments on Appellant's Home Help Services ("HHS") grant on [redacted]?

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 female beneficiary of the Medicaid and SSI welfare programs.

2. Appellant's diagnoses include: Dm 11; diabetic neuropathy; RTN; morbid obesity; Osteoarthritis of knees; breast cancer. (Exhibit A.8).

3. On [redacted] the Department received a referral on behalf of Appellant for the HHS program. (Exhibit A.7).

4. On [redacted] the Department did an in-home assessment with for Appellant and her caregiver. (Exhibit A.11).

5. On [redacted] the Department issued an approval notice for a HHS grant with a start date of [redacted]. (Exhibit A.9)

6. On [redacted] MAHS received a request for an administrative hearing arguing that her referral date was [redacted], and that the 45 day mark was reached and she was still not contacted by the DHS regarding the disposition of her application. (Exhibit A.5).

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 (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

Certain services are not covered by HHS. ASM 101 provides a listing of the services not covered by HHS.

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.

Adult Services Manual (ASM) 101, 11-1-2011,
Pages 3-4 of 4.

Specific policy from the Home Help Providers policy states in relevant part:

PROVIDER CRITERIA:

Determine the provider's ability to meet the following **minimum** criteria in a face-to-face interview with the client **and** the provider.

The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.

PROVIDER INTERVIEW

An initial face-to-face interview must be completed with the home help provider. A face-to-face or phone contact must be

made with the provider at the six month review or redetermination to verify services are being furnished.

ASM 135, page 2 of 9. Effective 12-1-2013

Note: A medical need form does not serve as an application for services. If the local office receives the DHS-54A, a referral must be entered on ASCAP for the date the form was received in the local office and an application sent to the individual requesting services. ASM 110. Effective 10-1-2014

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Specific to the case herein is ASM 115 where it states that "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." ASM 115, p.2 Also specific to the case herein is the following policy from ASM 115 as well as ASM 110 cited above: "The medical needs form does not serve as the application for services."

In this case, Appellant does not dispute the amount of the grant, but rather, the start date. The DHS began payments on [redacted] and the DHS argues that this start date be upheld as consistent with policy. Appellant requests that the start date for payments should be either the date the DHS-54 was signed by the physician-[redacted], or, the date the application form was turned in to the DHS-[redacted].

In support of his argument, Appellant argues that there is a standard of promptness of 45 days that would require that the start date be no later. Here, evidence by the Department indicates that the referral date was [redacted] Appellant in her hearing request states that the date was [redacted]. Appellant did not offer any authority-law or policy-that would support that a standard of promptness entitles an individual to benefits where the Department does not complete the assessment and where an individual would not be otherwise eligible. Generally, an SOP is viewed as a right without a remedy. Administrative law is not governed by contract law; there is no quid-pro-quo. Appellant cannot prevail where eligibility does not otherwise exist. The State of Michigan can be subject to substantial financial penalties for failure to comply with policy including necessary verifications contained in an applicant's file.

Appellant also argues in the alternative that the start date should be the date the DHS-54A was signed- [redacted]. Appellant did not offer any evidence into the record to support this argument. At hearing, Appellant argued that the ASW has no authority to determine a need but that is done only by a doctor, and that the ASW only determines rank. Both of Appellant's arguments are clearly contrary to explicit HHS policy cited above.

Under the above cited federal and state law, there can be no case opening where all eligibility criteria have not been met. Among those, is the requirement that there be a

face-to-face interview. Here, the interview was not done until [redacted]. Thus, the Department could not start payments before this date, regardless of who was at fault for delaying the processing of the case. As federal and state law requires an a Medicaid recipient's file to contain all required eligibility verifications, and as the failure to have the same can subject the state of Michigan to substantial financial penalties, this ALJ must uphold the start date as [redacted] as it is the earliest the Department could begin payments under Department policy and procedure.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's start date of [redacted] for Appellant's HHS grant was correct.

IT IS THEREFORE ORDERED THAT:

The Department's determination of [redacted] as the start date for Appellant's HHS grant is hereby 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.