STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-016247 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.*, and upon Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant's mother and provider appeared and testified on behalf of Appellant. Appellant has cognitive deficiencies. [redacted], Appeals Review Officer; and [redacted], Adult Services Worker appeared and testified on behalf of the Department of Health and Human Services (Department).

State's Exhibit A pages 1-32 were admitted as evidence.

ISSUE

Did the Department properly assess 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. Appellant is a Medicaid benefit recipient.

2. On [redacted], the Department received a referral for HHS on appellant's behalf.

3. On [redacted], the medical certification was completed.

4. Appellant has been diagnosed with Chronic Obstructive Pulmonary Disease, Fibromyalgia and Chronic Back Pain. State's Exhibit A page 7

5. On [redacted] a HHS home review was conducted.

6. On [redacted] the Department caseworker sent Appellant a Services and Payment Approval Notice informing her that HHS had been approved in the amount of $[redacted] for 54 hours and 40 minutes per month, effective [redacted].

7. Appellant is granted HHS for assistance in her home. She is granted assistance with bathing, dressing, transferring, mobility, medication, housework, laundry, shopping and meal preparation. State's Exhibit A page 12.

8. On [redacted], a HHS home review was conducted. The worker noted that Appellant had one change in her medications which was noted in the case. State's Exhibit A page 10.

9. Department records do not indicate a change in HHS benefit hours as a result of the [redacted] face to face home visit.

10. On [redacted], Appellant filed a request for a hearing stating that presently she is receiving 54 hours and 50 minutes of HHS and she needs more hours.

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.

Pertinent Department Policy states:

Clients have the right to contest a department decision affecting eligibility or benefit levels whenever they believe the decision is incorrect. The department provides an administrative hearing to review the decision and determine its appropriateness in accordance to policy. This item includes procedures to meet the minimum requirements for a fair hearing.

Efforts to clarify and resolve the client's concerns must start when the hearing request is received and continue through the day of the hearing. Bridges Administrative Manual (BAM) 600, page 1

Dissatisfaction with a department action may be expressed, orally or in writing, without specifically requesting a hearing. Determine whether there is actually a desire to request a hearing. If so, ensure that the request is put in writing. The DHS-18, Request for Hearing, available from DHS, may be used. Note the date of receipt of the original written request on the form/notice. BAM 600, page 2

MAHS may grant a hearing about any of the following:

- Denial of an application and/or supplemental payments.
- Reduction in the amount of program benefits or service.
- Suspension or termination of program benefits or service.
- Restrictions under which benefits or services are provided.
- Delay of any action beyond standards of promptness.
- For **FAP only**, the current level of benefits or denial of expedited service. BAM 600 page 5.

Home Help Services 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.

Appellant's request for a hearing is timely as the re-assessment was conducted [redacted] and the request for a hearing was received on [redacted].

Adult Services Manual 101 (11-1-2011) (hereinafter "ASM 101") addressed the issue of payment services for Home Help at the time of the denial in this case:

> **Payment Services for 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.
>
> 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.

ASM 120, page 1, specifically states:

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.

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

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

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment indicating a functional limitation of level 3 or greater for at least one activity of daily living (ADL).
- Appropriate Level of Care (LOC) status. ASM 105, page 1

The adult services specialist is responsible for determining the necessity and level of need for home help services based on all of the following:

- 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. ASM 105, page 3

A referral may be received by phone, mail or in person and must be entered on ASCAP upon receipt. The referral source does not have to be the individual in need of the services. The adult services specialist must determine eligibility within the 45 day standard of promptness which begins from the time the referral is received and entered on ASCAP. The referral date entered on ASCAP must be the date the referral was received into the local office. The computer system calculates the 45 days beginning the day after the referral date and counting 45 calendar days. If the due date falls on a weekend or holiday, the due date is the next business day.

When a signed DHS-390 serves as the initial request for services, the referral date must be the date the application was received in the local office. ASM 110, page 1

Moreover, with respect to the authorization of payments, Adult Services Manual 140 (11-1-2011) (hereinafter "ASM 140") states:

> **ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)**
>
> The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. The Adult Services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.
>
> *No payment can be made unless the provider has been enrolled in Bridges*. Adult foster care, homes for the aged and home help agency providers must also be registered with Vendor Registration; see ASM 136, Agency Providers.
>
> **Note:** The adult services home page provides a link to the provider enrollment instructions located on the Office of Training and Staff Development web site.
>
> Home help services payments to providers must be:
>
> - *Authorized for a specific period of time and payment amount.* The task is determined by the comprehensive assessment in ASCAP and will automatically include tasks that are a level three or higher.

- Authorized **only** to the person or agency actually providing the hands-on services.

  Note: An entity acting in the capacity of the client's fiscal intermediary is not considered the provider of home help and must not be enrolled as a home help provider; see ASM 135, Home Help Providers.

- Made payable jointly to the client and the provider.

Exception: Authorizations to home help agency providers are payable to the provider only. There are circumstances where payment authorizations to the provider only are appropriate, for example, client is physically or mentally unable to endorse the warrant. All single party authorizations must be approved by the supervisor.

- Prorate the authorization if the MA eligibility period is less than the full month. [ASM 140, page 1 of 3 (italics added).]

Pertinent DHS policy dictates:

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.

The determination of provider criteria is the responsibility of the adult services specialist.

Adult Services Manual 135, page 1, ASB 2013-004, December 1, 2013.

All home help providers **must** be enrolled in Bridges by a designee at the local county DHS office prior to authorizing payment. Once a provider is enrolled, Bridges will assign the provider a seven digit identification number. The adult services specialist must allow 24 hours from the time of enrollment for Bridges to interface with ASCAP. *ASM 135, page 4.*

ASM 136, which governs agency providers, indicates that Agency/business providers have the option of submitting monthly invoices in lieu of the DHS-721, Provider Log. Each invoice must specify the following:

- The services provided.
- The date(s) of service.

Department policy explicitly dictates:

The assessment must be updated **as often as necessary**, but **minimally** at the six month review and **annual** redetermination.

The Department ASW was required to conduct the redetermination assessment with Appellant in [redacted]. The ASW conducted the interview in accordance with policy. The ASW was also required to take action on the redetermination. The ASW did not notify Appellant of any action he had taken, whether an increase, remain the same or decrease, in HHS occurred as a result of the reassessment interview. The HHS benefits remained the same and continued in uninterrupted fashion. The Department ASW alleges that there has been no change in Appellant's condition and that the assessment is appropriate. The Department also alleges that there was only one provider agency in the county in which Appellant lives at the time of the complaint, but now there is an additional provider agency that can provide services to the client. The caseworker indicated that he spoke to the provider agency and the agency worker indicated that Appellant often wants the provider to spend time with her in addition to performing the HHS duties and that is not what they are being paid for. The caseworker testified that he will put Appellant in contact with the new provider agency and assist with the transfer of services.

Appellant testified on the record that she is not satisfied with the work provided by the people who come to assist her with HHS and that they don't perform all of the hours that the Department has provided her with. She is often left in her same clothes for days and her laundry is not done for months. She has complained but is afraid to keep complaining because she needs the help.

Department policy explicitly dictates:

Adult protective services provide protection to vulnerable adults who are at risk of harm due to the presence or threat of any of the following:

- Abuse.
- Neglect.
- Exploitation.

This program addresses the goal of protection.

This program will:

- Provide immediate (within 24 hours) investigation and assessment of situations referred to the agency when a vulnerable adult is suspected of being or believed to be abused, neglected, or exploited.

- Assure that adults in need of protection are living in a safe and stable situation, including legal intervention, where required, in the least intrusive or restrictive manner. Adult Service Manual, ASM 200, page 1

Department policy dictates that Appellant may request an additional in-home assessment to determine if appellant is entitled to receive additional HHS.

Department policy requires that Department workers continually reassess case planning to provide the necessary supports to clients to enhance and preserve the client's quality of life.

If Appellant is dissatisfied with the services she receives from the provider agency she is entitled to request an additional assessment. Appellant testified that she has not received the services that the Department is paying for. This creates a report that Appellant is at risk from harm from abuse, neglect, or exploitation. She is in need of assistance with ADLs which renders her vulnerable and in need of possible protective services. She is entitled to hire a new provider, which is a separate issue and must be addressed with the provider agency. However, because she is a vulnerable adult, she may need assistance with this task. Moreover, the testimony on the record indicates that until very recently there has been only one enrolled provider agency available to provide the services to Appellant. Thus, there was no viable alternative for Appellant if she was not happy with her services.

The Department must take action when an Appellant requests a reassessment of HHS benefits. If Appellant states that she is not being provided with the services that the Department has been paying for, the Department has the explicit duty to investigate the allegations.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant has established by a preponderance of the evidence that she is entitled to a re-assessment of her HHS benefits case to determine if she is eligible to receive additional or extended HHS.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **REVERSED**. The Department is **ORDERED** to conduct a re-assessment of Appellant's eligibility for HHS, investigate Appellant's allegations of provider misconduct, and as agreed, to put Appellant into contact with the new provider agency in Appellant's county and assist her with the transfer of HHS services to that new provider agency.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: November 3, 2015

Date Mailed: November 6, 2015

LYL[redacted]

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.