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. 15-017173 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 personally appeared and testified. [redacted] appeared as a witness.

[redacted], Appeals Review Officer, represented the Department. [redacted] Adult Services Supervisor, (ASS), and [redacted], Adult Services Worker (ASW) appeared as witnesses for the Department.

ISSUE

Did the Department properly process 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. At all relevant times, Appellant has been and continues to be beneficiary of the welfare Medicaid and SSA programs.

2. Appellant is a[redacted] year old female. Appellant's impairment(s) includes a report of a tumor 5 years ago. The Department failed to include the DHS-54A in the evidentiary packet. (Exhibit A).

3. In [redacted] Appellant's HHS case closed based on misinformation from the DHS that Appellant had not met her spend-down. DCH failed to issue written notice of the closure. Appellant was verbally informed of the closure. (Testimony).

4. The DHS benefits division incorrect indicated on the Bridges data system that Appellant had not met her spend-down since [redacted]. On or about

[redacted], the DHS division corrected the error and issued a notice indicating that Appellant has had full MA coverage since [redacted]. (Appellant Exhibit I; Testimony).

5. On [redacted] Appellant had a DHS administrative hearing with [redacted] who ordered the Department to reassess Appellant's MA eligibility. Appellant testified that the Department determined that Appellant was eligible for full MA but incorrectly reopened Appellant's case as a spend-down. (Testimony). [redacted] decision clearly indicates that Appellant only has a right to review for 90 days prior to the date of her administrative hearing request. (ALJ Burke, Reg. No: 15-002662).

6. Appellant had actual or imputed knowledge of the 90 day hearing requirement. Appellant's present hearing request is dated [redacted], allows for a review to [redacted]

7. On [redacted] Appellant filed a hearing request with MAHS for multiple issues, including a request to review of her Medicaid spend-down since [redacted] and for a review of how the spend-down error affected Appellant's HHS case.

8. In [redacted], Appellant made a new referral for HHS benefits based on ALJ Burke's recommendation. (Testimony).

9. Pursuant to the new referral, Appellant's physician filed a DHS-54A from Appellant's physician indicating that Appellant did not have any needs for any ADLs. On [redacted] the Department issued a Negative Action Notice denying the referral based on the lack of a medical certification. The Department subsequently contacted Appellant's physician who stated that the form contained errors, and delivered an updated DHS-54A showing medical certification on [redacted] (Exhibit A.14-15).

10. Appellant's provider was certified on [redacted]. The Department began HHS payments on [redacted]. (Exhibit A).

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) 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.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. Completed DHS-54A or veteran's administration medical forms are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

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 2-3 of 3

Adult Services Manual (ASM) 120, 5-1-12, addresses the 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 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.
> - 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 IADL's 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.

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

Adult Services Manual (ASM) 101, 11-1-11, addresses 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.

MEDICAL NEEDS FORM (DHS-54A)

The DHS-54A, Medical Needs form must be signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:

- Physician (M.D. or D.O.).
- Nurse practitioner.
- Occupational therapist
- Physical therapist.

Note: A physician assistant (PA) is not an enrolled Medicaid provider and **cannot** sign the DHS-54A.

The medical needs form is only required at the initial opening for SSI recipients and disabled adult children (DAC). All

> other Medicaid recipients must have a DHS-54A completed at the initial opening and annually thereafter.
>
> The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.
>
> The medical professional certifies that the client's need for service is related to an existing medical condition. **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.
>
> If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional.
>
> Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.
>
> The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is **before** the date on the DHS-390, payment for home help services must begin on the date of the application. ASM 115, page 1 of 3. 5-1-2013 Effective Date.

Prior to any substantive review, jurisdiction must be established. Here, Appellant requests that this forum review her eligibility and benefits since [redacted]. However, Appellant did not file the hearing request for an administrative hearing with the DCH until [redacted]. As noted in the Findings of Fact, Appellant had an evidentiary hearing pursuant to a hearing request filed with DHS with ALJ Burke on 3/23/15. At that time, Appellant was fully informed of the law and policy that does not allow review except for 90 days prior to the filing of a request. Appellant's HHS case closed in March, 2015. The Department failed to issue written notice but Testimony indicates that Appellant was informed verbally. This ALJ finds that Appellant knew or should have known about the 90 day law and policy; that is, Appellant had actual or imputed knowledge of the 90 day rule. Thus, this ALJ finds that Appellant has a right to a review for 90 days prior the [redacted] filing of her hearing request.

In addition to the policy cited above, ASM policy that does not allow the department to open an HHS and issue payments until the beneficiary's provider has an enrollee ID and has been enrolled in the Bridges data system.

Here, evidence shows that Appellant's current provider was certified [redacted]. Thus, under federal and state law, payments could not have been issued sooner.

In addition, policy does not allow for the issuance of HHS benefits absent a DHS-54A medical certification from the applicant's physician. As noted above, Appellant's physician first indicated no eligibility; it was not until [redacted] that the physician filed a DHS-54A certifying eligibility. At the time the [redacted] DCH denial, Appellant's verifications failed to meet the federal and state requirement for the HHS program. Thus, the denial must be upheld.

Here, the Department made a number of errors. While these errors were subsequently corrected, there can be no issuance of benefits absent an applicant being 'otherwise eligible.' Unfortunately for Appellant, the evidence shows that Appellant was not 'otherwise eligible' during the 90 day review period herein until [redacted], at which time Appellant's provider was approved on Bridges. Evidence show that the DCH opened Appellant's case and issued benefits on that date and forward.

Under the evidence here and the facts shown, this ALJ must find that the Department's opening of Appellant's HHS and issuance of benefits beginning on [redacted] was correct and there is no evidence that Appellant would have been otherwise eligible prior to this date.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Spodarek

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]
Date Mailed: [redacted]

[redacted]
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JS/cg

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.