STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(800) 648-3397; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-020959 HHS
Case No.

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 hearing was held on . , the Appellant, appeared on his own behalf. , chore provider, appeared as a witness for Appellant. , Appeals Review Officer, represented the Department of Health and Human Services (Department). , Adult Services Worker (ASW) appeared as a witness for the Department.

ISSUE

Did the Department properly reduce Appellant's Home Help Services (HHS)?

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 beneficiary who has been authorized for HHS. (Department Exhibit A, p. 21)

2. Appellant has been diagnosed with quadriplegia, ventilator dependent, and osteomyelitis. (Department Exhibit A, p. 15)

3. On , the Department's ASW went to Appellant's home to conduct a reassessment. There was some discussion about how many hours per day each of Appellant's HHS providers works and what assistance is provided by each of them. (Department Exhibit A, p. 14; ASW Testimony)

4. On , the Department sent Appellant an Advance Negative Action Notice informing him that the HHS authorization would be reduced to $ effective . (Department Exhibit A, pp. 6-8)

5. Appellant's Request for Hearing was received by the Michigan

Administrative Hearing System on [redacted]. (Department Exhibit A, pp. 4-5)

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, 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,
December 1, 2013, Page 1 of 5

Adult Services Manual (ASM) 105, 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 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 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.

  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 if assessed at a level 3 or greater.

  Example: Ms. Smith is assessed at a level 4 for bathing. However, she refuses to receive assistance or her daughter agrees to assist her at no charge. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

  Note: If an individual uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the individual must be ranked a level 3 or greater on the functional assessment. This individual would be eligible to receive home help services.

  Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

  Assistive technology includes such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and hand held showers.

- 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,
April 1, 2015, Pages 1-4 of 4

Adult Services Manual (ASM) 120, 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. This 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 if assessed at a level 3 or greater.

Example: Ms. Smith is assessed at a level 4 for bathing. However, she refuses to receive assistance or her daughter agrees to assist her at no charge. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

Note: If an individual uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the individual must be ranked a level 3 or greater on the functional assessment. This individual would be eligible to receive home help services.

Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

Assistive technology includes such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and hand held showers.

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.

Complex Care Needs

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are per-formed on client's whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or client may be required in order to perform.

- Eating and feeding.
- Catheters or legs bags.

- Colostomy care.
- Bowel program.
- Suctioning.
- Specialized skin care.
- Range of motion exercises.
- Peritoneal dialysis.
- Wound care.
- Respiratory treatment.
- Ventilators.
- Injections.

When assessing a client with complex care needs, refer to the com-plex care guidelines on the adult services home page.

Time and Task

The specialist will allocate time for each task assessed a rank of 3 or greater, 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, a rationale **must** be provided.

An assessment of need, at a ranking of 3 or greater, 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 (IADL) 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.

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Expanded Home Help Services (EHHS)

Expanded home help services exists if all basic home help services eligibility criteria are met and the assessment indicates the client's needs are so extensive that the cost of care cannot be met within the monthly maximum payment level of $549.99.

Michigan Department of Community Health Approvals

When the client's cost of care exceeds $1299.99 for **any** reason, the adult services specialist must submit a written request for approval to the Michigan Department of Community Health (MDCH).

Follow the **Procedures for Submitting Expanded Home Help Requests** found on the Adult Services Home Page. Submit the request with all required documentation to:

Michigan Department of Community Health
Long Term Care Services Policy Section
Capital Commons Building, 6th Floor
P.O. Box 30479
Lansing, MI 48909

MDCH will provide written documentation (DCH-1785) of approval. A new request **must** be submitted to the Michigan Department of Community

Health whenever there is an increase in the cost of care amount. A new request is **not** require if the cost of care decreases below the approved amount set by MDCH.

Note: If an expanded home help case closes and reopens within 90 days and the care cost remains the same, a new MDCH approval is **not** required.

Adult Services Manual (ASM) 120, December 1, 2013, Pages 1-7 of 7 (emphasis in original)

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). A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18.
- 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, December 1, 2013, Pages 3-4 of 5.

It is noted that on [redacted], the Department's central office authorized not only EHHS for Appellant, but also an exception to policy regarding 24 hour care for Appellant. The EHHS approval was for up to 658 hours per month with a total care cost of $[redacted]. It was specified that further central office review would only be required when the authorization amount needs to be increased. (Department Exhibit A, p. 18) A

total of 658 hours per month would be just short of compensating for 24 hours of assistance per day. In a 30 day month, a total of 658 hours would equal almost 22 hours of paid care per day.

On , the Department's ASW went to Appellant's home to conduct a reassessment. The ASW noted that Appellant's limitations and needs for service remained the same. The ASW testified that the changes to Appellant's HHS authorization were based the information reported by one of the HHS providers (E.T.) during the home visit that the other HHS provider (J.B.) is only there from 5:00 pm to 11:00 pm and does not usually do the IADL activities that are under his portion of the time and task approval. E.T. indicated she is there from 11:00 pm to 5:00 pm, and provides most of the care. The ASW also testified that Appellant basically gets 24 hour/day care. (Department Exhibit A, p. 14; ASW Testimony)

The ASW's narrative note and testimony indicate there was no determination that Appellant's HHS needs had changed. Rather, the ASW's testimony indicated the HHS hours were being adjusted to match the report of what activities/how much time each provider was actually providing care. However, a comparison of the prior time and task approval and current time and task approval shows that the action taken was not just a matter of adjusting the HHS hours between the two HHS providers. There was an overall reduction of about 33 hours per month for J.B., the provider that is present from 5:00 pm to 11:00 pm. It is also noted that the same IADL times and tasks remained under his portion of the time and task authorization, despite the report to the ASW that this provider does not usually do the IADL tasks authorized. Further, there was also a reduction of about 20 hours per month for E.T.'s HHS hours, the provider that is present from 11:00 pm to 5:00 pm. The changes in E.T's portion of the time and task authorization included a reduction to the times for activities like grooming and mobility, as well as the elimination of all hours for specialized skin care. (Department Exhibit A, pp. 16-17 and 19-20) The ASW did not indicate any reason(s) for any reductions to E.T.'s portion of the time and task authorization. Further, without any determination of a change in Appellant's care needs or any report that together HHS providers are present less than 24 hours per day, it is unclear why the overall HHS authorization for this assessment was reduced from about 451 hours per month to about 398, a total reduction of about 53 hours per month. (Department Exhibit A, pp. 16-17 and 19-20)

Appellant also raised additional issues from the , assessment. Appellant described the circumstances and conflict between the HHS providers enrolled at that time. Appellant is ventilator dependent, so his voice is low. Appellant testified that at times he felt talked over during the home visit. During the home visit there were times when Appellant tried to get the ASW's attention, but he was not successful. Accordingly, it appears that the ASW did not give Appellant an adequate opportunity to provide his own information during the home visit. Additionally, Appellant indicated he is not comfortable having all of his information discussed in front of others. For example, the HHS providers did not need to know about Appellant's financial resources. (Appellant Testimony) As discussed during the hearing proceedings, it may be beneficial if others, such as the HHS providers, are asked to leave the room for a

portion of the HHS assessment to respect Appellant's privacy and to ensure Appellant has an adequate opportunity to provide information to the ASW.

Additionally, it appears there was a misunderstanding during this assessment regarding Appellant's request to add a third HHS provider. (Appellant and ASW Testimony) The ASW indicated this request could not be granted because Appellant already had 24 hour care approved. (ASW Testimony) A review of the time and task authorization shows that the Department had not been authorizing 24 hours care, let alone the up to 658 hours per month approved by the Department's central office. (See Department Exhibit A, p. 18) While this ALJ understands that Appellant's HHS providers are likely providing more types of assistance than can be compensated under the HHS program, such as periods of only supervision or medical transportation, the authorization at issue only totaled about 398 hours per month. Accordingly, the ASW's implication that there were no hours left in the day to add in a third HHS provider cannot be found accurate. Additionally, Appellant's testimony indicated he was not trying to get more than 24 hours of care. Rather, Appellant wanted to divide the total HHS authorization between three care givers, like he used to be allowed to do. There is understandable concern that only two persons providing 24 hour care on a daily basis may get burned out. There was nothing found in HHS policy that was preclude dividing Appellant's HHS authorization between three enrolled providers instead of two providers.

The preponderance of the evidence in this case establishes that this assessment and resulting reduction in Appellant's HHS authorization were improper. The ASW's testimony regarding the reasons for the adjustment of the HHS hours does not support the actual changes made to the HHS authorization. It also appears that Appellant was not given an adequate opportunity to provide information during the home visit and there was a misunderstanding regarding the request to add a third HHS provider.

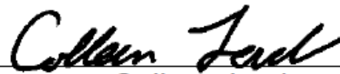
Lastly, Appellant asked about the potential effective date if the Department's determination is reversed. (Appellant Testimony) If upon re-assessment, the Department determines that Appellant's HHS authorization should be increased, the authorization can be made retroactive to the [redacted], effective date if sufficient information is provided to the Department to establish that the authorized services were actually provided by the enrolled HHS providers.

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 improperly reduced Appellant's HHS.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is **REVERSED**. The Department shall initiate a reassessment of Appellant's HHS case in accordance with Department policy, which would include issuing written notice of the determination. If the Department determines that Appellant's HHS authorization should be increased, the authorization can be made retroactive to the , effective date if sufficient information is provided to the Department to establish that the authorized services were actually provided by the enrolled HHS providers.



Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

CL/

Date Mailed: February 5, 2016

cc:

***** 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.