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

IN THE MATTER OF:

[redacted] **Docket No.:** 15-015257 HHS
[redacted] [redacted]

Appellant

I

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] appeared on the Appellant's behalf. [redacted] [redacted] Appeals Review Officer, represented the Department of Health and Human Services. [redacted], Adult Services Worker (ASW), appeared as a witness for the Department.

ISSUE

Did the Department properly determine the Appellant's Home Help Services (HHS) benefits allocation and did they properly enroll the Appellant's Provider?

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 some point in time prior to [redacted] the Appellant requested HHS. (Exhibit A, p 27; Testimony)

2. On [redacted] the ASW met with the Appellant and completed a HHS assessment. During the assessment, the ASW and the Appellant reviewed a corresponding medical needs form and discussed the Appellant's needs for hands on care with her Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). (Exhibit A, pp 24, 25; Testimony)

3. On or around [redacted], the ASW determined the Appellant's time and task allocations based upon the assessment conducted on [redacted]. (Exhibit A, p 29; Testimony)

4. On [redacted], the Department sent the Appellant a services and payment approval notice. The notice indicated the Appellant was being approved for HHS in the monthly amount of [redacted] equating to [redacted] hours and [redacted] minutes a month of service. (Exhibit A, pp 12, 29; Testimony)

5. Between [redacted] and [redacted] several discussions took place between the Appellant's Provider [redacted] and the Department regarding whether or not [redacted] company was to be recognized as an Agency provider and receive the corresponding Agency rate. During these discussions, the Department informed [redacted] as to what she needed to do to be recognized as an Agency provider. (Exhibit A, pp 24-24; Testimony)

6. The Department utilizes a published list from the Department of Community Health to determine whether or not an Agency is recognized as an Approved Agency provider. (Testimony)

7. As of [redacted] [redacted] company was not on the Department of Community Health approved agency list. (Testimony)

8. The Department of Community Health issues approved Agency providers a letter signifying their approval on the approved agency list. [redacted] never received one of these letters. (Testimony)

9. On [redacted], the Michigan Administrative Hearings System (MAHS) received from the Appellant a request for hearing. (Exhibit A, pp 4-11)

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.

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.
>
> *ASM 101,*
> *12-1-2013, Page 1of 4.*

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 (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
> - Appropriate Level of Care (LOC) status.
>
> ***
>
> **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.

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.

ASM 105,
4-1-2015, Pages 1, 3, 4 of 4

ASM 120, pages 1-5 of 5 addresses the adult services comprehensive assessment and responsible relatives:

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.

Responsible Relatives

Activities of daily living may be approved when the responsible relative is **unavailable** or **unable** to provide these services.

> **Note: Unavailable** means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. **Unable** means the responsible person has disabilities of their own which prevent them from providing
>
> care. These disabilities must be documented/verified by a medical professional on the DHS-54A, Medical Needs form.
>
> Do **not** approve shopping, laundry, or light housecleaning, when a responsible relative of the client resides in the home, **unless** they are unavailable or unable to provide these services. Document findings in the general narrative in ASCAP.
>
> **Example:** Mrs. Smith is in need of home help services. Her spouse is employed and is out of the home Monday thru Friday from 7a.m. to 7p.m. The specialist would not approve hours for shopping, laundry or house cleaning as Mr. Smith is responsible for these tasks.
>
> **Example:** Mrs. Jones is in need of home help services. Her spouse's employment takes him out of town Monday thru Saturday. The specialist may approve hours for shopping, laundry or house cleaning.
>
> *ASM 120, 12-1-2013,*
> *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.

ASM 101, 12-1-2013,
Pages 3-4 of 4

ASM 136 addresses Agency Providers.

Agency Definition and Criteria

A home help services provider is eligible to be approved as an agency when either of the following criteria are met:

- A Medicaid enrolled home health agency.
- Has a Federal Tax Identification number, also known as Employer Identification Number (EIN), AND employs or (sub) contracts with two or more persons, not including the owner, to provide home help services.

When an agency has met the above requirements, it will fall into one of two categories. It will be either an agency that employs its service providers or an agency that subcontracts with its service providers.

Verification of Agency Status

The adult services specialist should instruct agencies to submit the required documentation for agency status approval to:

Michigan Department of Community Health
Long Term Care Services Policy Section
Capital Commons Building, 6th Floor
400 S. Pine Street
P.O. Box 30479
Lansing, Michigan 48909-7979
OR
Fax to 517-335-7959

Agencies will receive a determination letter from MDCH stating one of the following:

- The agency has met the criteria and is approved (agencies are often given provisional approval status).
- The agency has not met the criteria and is denied.
- The agency must submit additional information in order to meet the requirements.

MDCH will randomly select agencies and request documentation to review agency status. An agency must notify the adult services specialist within 10 business days of any changes that may affect meeting the agency requirement.

Agency Approval List

A list of approved agencies is maintained on the Adult Services Home Page. If an agency is on the Home Help Agency List, their status as an approved agency extends to all counties.

ASM 136, 12-1-2013
Pages 1-3 of 6

The ASW testified that the time and task allocations were based upon the assessment that was conducted in [redacted] that the Provider did not participate in. The ASW also testified she was not able/allowed to assign the Appellant's Provider as an Agency provider as the Appellant's Provider could not be found on the approved list.

The Appellant's Representative provided very little argument as to why the original time and task allocations were inadequate. Additionally, the Appellant's Representative did not provide any evidence that the Appellant's Provider was on the approved list of Agency Providers.

Based on the evidence presented, Appellant has failed to prove, by a preponderance of the evidence, that she requires more HHS benefits than what she was approved for and has not provided any evidence that her provider is on the approved agency provider list. Accordingly, I find evidence to affirm the Department's actions in this matter.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly determined the Appellant's HHS benefits and properly enrolled the Appellant's provider.

IT IS THEREFORE ORDERED THAT:

The Department's decision is Affirmed.

Corey A. Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed : [redacted]

CAA/db

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.