[redacted]
[redacted] MI [redacted]

Date Mailed: February 29, 2024
MOAHR Docket No.: 24-001003
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

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 Petitioner's request for a hearing.

After due notice, a hearing was held on February 27, 2024. [redacted] Petitioner's Authorized Hearing Representative (AHR), appeared and testified on Petitioner's behalf. Leigha Klaver, Appeals Review Officer, appeared on behalf of Respondent, Michigan Department of Health and Human Services (MDHHS or Department). Janice Thompson, Adult Services Worker (ASW), and Margo Peterson, Adult Services Program Manager, appeared as witnesses for the Department.

ISSUE

Did the Department properly deny Petitioner'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. Petitioner is a Medicaid beneficiary, who applied for HHS on [redacted] (Exhibit A, p 22; Testimony)

2. Petitioner has a Medicaid scope of coverage of 1Y, Plan First Family Planning Program. (Exhibit A, pp 23, 42-45; Testimony)

3. Petitioner is diagnosed with end stage dementia, hypertension, osteoarthritis, and ataxic gait. (Exhibit A, p 12; Testimony)

4. On October 20, 2023, the ASW sent Petitioner introductory paperwork, which indicated that the included 54-A Medical Needs Form needed to be returned within 21 days, or by November 10, 2023. (Exhibit A, p 27; Testimony)

5. On November 15, 2023, the Department's ASW sent Petitioner a Negative Action Notice indicating that HHS was denied for failure to return the 54-A within the 21 days allowed by policy. (Exhibit A, p 24; Testimony)

6. On November 15, 2023, the Department's ASW also sent Petitioner a letter informing Petitioner that she was not eligible for HHS because her Medicaid scope of coverage was 1Y. (Exhibit A, p 28; Testimony)

7. On January 29, 2024, Petitioner's hearing request was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit A, pp 9-21)

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.

The Adult Services Manual (ASM) address issues of what services are included in Home Help Services and how such services are assessed:

ASM 105 ELIGIBILITY CRITERIA

GENERAL

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Requirements

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

- Medicaid eligibility.
- Appropriate program enrollment type (PET) code.
- 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).

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Medicaid Eligibility

The client may be eligible for Medicaid (MA) when either all requirements for Medicaid eligibility have been met, or the Medicaid deductible obligation has been met. The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).
- 3G (Healthy Michigan Plan).
- 7W (MI Child).
- 8L (Flint).

Clients with a scope of coverage 20, 2C, or 2B are not eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in the Michigan Adult Integrated Management System (MiAIMS) for active services cases

Adult Services Manual (ASM) 115 addresses HHS requirements:

DHS-54A, MEDICAL NEEDS FORM

The DHS-54A, Medical Needs form must be signed and dated by a medical professional certifying a medical need for personal care services based on the existing medical condition, physical disability, or cognitive disability of the client. The medical professional must be an approved Medicaid provider, enrolled in CHAMPS, and hold one of the following professional licenses:

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

The DHS-54A, Medical Needs form is only required for Home Help clients at the initial opening of a case, unless one of the following exists:

- The ASW assesses a decline in the client's health which significantly increases their need for services, and clarification is needed from the medical provider.
- The ASW assesses an improvement in the client's ability for self-care, resulting in a decrease or elimination of services and the client states their care needs have not changed.
- The current DHS-54A has a specified time frame for needed services and that time frame has elapsed.

The client is responsible for obtaining the medical certification of need, but the DHS-54A must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form, 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, physical disability, or cognitive disability. **The medical professional does not prescribe or authorize personal care services**. Needed services are determined by the comprehensive assessment conducted by the adult services worker.

The date that the valid medical provider signs the DHS-54A is the medical certification date entered into MiAIMS.

If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.

If the case is denied and a new referral is made within 90 days of the original certification date on the DHS-54A, there is no need to obtain a new medical needs form unless there are changes in the condition of the client.

Veteran's Administration (VA)

A DHS-54A completed by a veteran's administration medical provider, or the VA medical form 10-10M, in lieu of the DHS-54A, is acceptable.

IMPORTANT DATES

When a signed DHS-390, Adult Services Application, serves as the initial request for services, the referral date must be the date the application was received in the local office.

The date that a valid client or guardian signature is received in the local office is the application date.

The DHS-54A, Medical Needs form does not serve as the application for services. If the signature date on the DHS-54A is before the DHS-390 received date, payment for Home Help services must begin on the application date.

Do not authorize Home Help services prior to the date of the medical professional's signature on the DHS-54A.

The case opening date for a Home Help case is the latter of the DHS-390 received date and the DHS-54A medical provider signature date.

Example: The local office adult services unit receives a DHS-54A signed on 07/18/2020, but a referral for Home Help had not been received yet. The adult services staff enters a referral on MiAIMS for 7/18/2020, and either mails an application to the client or sets up a home visit and brings the application to the client. The application is returned to the office on 08/07/2020. Payment cannot begin until 08/07/2020, or later, if the caregiver was not working during this period or was not enrolled in CHAMPS; see ASM 135, Home Help Caregivers.

Adult Services Manual (ASM) 115
May 1, 2023, pp 1-3 of 6
Emphasis added

Adult Services Manual (ASM) 110 addresses HHS eligibility requirements:

OVERVIEW

Individuals may send a referral for Home Help services by phone, mail, fax, or in person and referrals must be entered on the Michigan Adult Integrated Management System (MiAIMS) upon receipt. The referral source does not have to be the individual in need of the services.

Referral Registration

The taking of a referral for the Home Help program involves four steps:

1. Enter known information about the client into the *Quick or Advanced Search* in MiAIMS. The client search will provide one of three results:

   - No matching record found.
   - One result. One result will open the case in a 360 screen.
   - More than one result. More than one result lists possible matches to the client.

   In all three search results, add a new referral by clicking the *Add New Client/Add Referral* button under the *Client Action* section on MiAIMS.

2. Enter basic client information and demographics in the Client Information tab in MiAIMS.

3. Complete the Referral Information in MiAIMS by entering the referral date and time, source, and basic need for services.

   Note: If the referral date or time in MiAIMS is not the actual receipt of the referral, the date and time must be adjusted in MiAIMS.

4. Complete a Bridges search for eligibility, correct Medicaid, and appropriate program enrollment type (PET) code or benefit plan (BP). Upon saving a referral in MiAIMS a log referral ID number is generated.

Case Assignment and Disposition

The supervisor or their designee assigns the pending referral to the adult services worker (ASW) using the Assign Worker button under the Case Action section in MiAIMS.

Documentation

The ASW must print the introduction letter, the DHS-390, Adult Services Application, and the DHS-54A, Medical Needs form located in the Forms module and mail to the client. The introduction letter allows the client 21-calendar days to return the documentation to the local office.

Note: The introduction letter does not serve as adequate notification if Home Help services are denied. The ASW must send the client a DHS-1212A, Adequate Negative Action Notice; see ASM 150, Notification of Eligibility Determination.

Standard of Promptness (SOP)

The ASW must determine eligibility within the 45-day standard of promptness, which begins the day after the referral is received and entered on MiAIMS. The referral date entered on MiAIMS must be the date the referral was received in the local office. The computer system calculates 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.

Note: A DHS-54A, Medical Needs form does not serve as an application for services. If the local office receives a DHS-54A as the initial request for services, a referral must be entered on MiAIMS for the date the form was received in the local office and an application mailed or given to the individual requesting services. After receiving the assigned referral, the ASW gathers information through an assessment, contacts, etc. and decides to approve or deny the referral; see ASM 115, Adult Services Requirements.

CONTACT

For questions contact MDHHS-Home-Help-Policy@michigan.gov.

Adult Services Manual (ASM) 110
June 1, 2020, p 1-2
Emphasis added

The ASW testified that Petitioner has a Medicaid scope of coverage of 1Y, Plan First Family Planning Program. The ASW indicated that on October 20, 2023, she sent Petitioner introductory paperwork, which indicated that the included 54-A Medical Needs Form needed to be returned within 21 days, or by November 10, 2023. The ASW testified that on November 15, 2023, she sent Petitioner a Negative Action Notice indicating that HHS was denied for failure to return the 54-A within the 21 days allowed by policy. The ASW also indicated that on November 15, 2023, she sent Petitioner a letter informing Petitioner that she was not eligible for HHS because her Medicaid scope of coverage was 1Y.

Petitioner's AHR testified that she did not understand about the scope of coverage, and she was unable to get Petitioner's eligibility specialist to call her back. Petitioner's AHR also indicated that all the paperwork for HHS was sent to Petitioner's address, even though she included her own address as the contact information on the application. Petitioner's AHR testified that Petitioner is [redacted] years old, has dementia, and cannot care for herself.

In response, the Department's representatives indicated that they would reach out to Petitioner's eligibility specialist and ask her to call Petitioner's AHR. The Department's representatives also indicated that they have seen beneficiaries request an eligibility hearing through the local DHHS office to rectify the 1Y scope of coverage issue. The Department's representatives indicated, however, that the HHS program does not determine Medicaid eligibility.

Based on the evidence presented, Petitioner has failed to prove, by a preponderance of the evidence, that the Department erred in denying the HHS application. First, as indicated above, Petitioner has a Medicaid scope of coverage of 1Y, Plan First Family Planning Program, which makes her ineligible for HHS. Pursuant to ASM 105, also outlined above, to be eligible for HHS, a Medicaid beneficiary must have a scope of coverage of 1F or 2F, 1D or 1K (Freedom to Work), 1T (Healthy Kids Expansion), 3G (Healthy Michigan Plan), 7W (MI Child), 8L (Flint). So, regardless of the fact that the 54A Medical Needs Form was not returned on time, the Department's denial of Petitioner's HHS application was proper and must be upheld. Petitioner's AHR should immediately discuss Petitioner's eligibility with the eligibility specialist, Anita Hightower, and/or request an eligibility hearing through the local DHHS office for Petitioner as discussed.

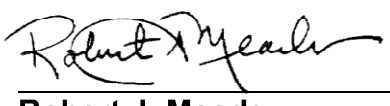
Furthermore, Petitioner did fail to return the 54A Medical Needs Form within the 21 days allowed by policy, even though the form may have possibly been sent to the wrong address (Petitioner's address instead of her AHR's address). However, given the evidence here, the denial of Petitioner's HHS application was proper and must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Petitioner's HHS application based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.



RM/sj

Robert J. Meade
Administrative Law Judge

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 29th day of February 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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