STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-32249 HHS
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted]. [redacted] appeared as a representative for the Appellant. The Appellant was present and verbally consented to have [redacted] represent her at hearing.

[redacted], represented the Department. [redacted] was present as a Department witness.

ISSUE

Did the Department properly reduce Home Help Services payments to the Appellant?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is an [redacted] Medicaid beneficiary who participates in the Home Help Services program.

2. The Appellant resides in her own apartment. She is ambulatory, using a walker for assistance. She also has an electric wheelchair for use.

3. The Appellant has suffered a stroke.

4. The Appellant's case was scheduled for an annual assessment in [redacted].

5. A Department worker completed a home call in conjunction with the review, [redacted].

6. The worker spoke with the Appellant at the home call. He was informed she no longer needed assistance with medication, toileting or transferring. He saw her walk unassisted at the home call.

7. The Department's worker reduced the Appellant's assistance payments for the home help program following the assessment conducted [redacted].

8. The Advance Negative Action Notice reducing payments was printed [redacted]. The effective date of the negative action, as printed on the Notice, is [redacted].

9. The Appellant was deprived of Advance Notice of the Department's reduction.

10. The Appellant requested a formal, administrative hearing [redacted].

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 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.

ELIGIBILITY FOR HOME HELP SERVICES

> Home help services (HHS) are defined as those, which the Agency is paying for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid (MA)

Verify the customer's Medicaid/Medical aid status.

The customer may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**
- MA spend-down obligation has been met.

Adult Services Manual (ASM) 9-1-2008

Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Customer choice.
- A complete comprehensive assessment and determination of the customer's need for personal care services.

• Verification of the customer's medical need by a Medicaid enrolled medical professional. The customer is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:

- Physician
- Nurse Practitioner
- Occupational Therapist
- Physical Therapist

The physician is to certify that the customer's need for service is related to an existing medical condition. The physician does not prescribe or authorize personal care services.

If the Medical Needs form has not been returned, the adult services worker should follow-up with the customer and/or medical professional.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system

provides the format for the comprehensive assessment and all information will be entered on the computer program.

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 customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the customer'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
- Housework

Functional Scale ADL's and IADL's 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.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater.

Time and Task

The worker will allocate time for each task assessed a rank of 3 or higher, based on the 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.

IADL Maximum Allowable Hours
There are monthly maximum hour limits on all IADLs 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.

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements. If there is a need for expanded hours, a request should be submitted to:

* * *

Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the Client does not perform activities essential to the caring for self. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.
- The kinds and amounts of activities required for the client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client does not perform. Authorize HHS only for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. Unable means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS-54A.

- Do not authorize HHS payments to a responsible relative or legal dependent of the client.
- The extent to which others in the home are able and available to provide the needed services. Authorize HHS only for the benefit of the client and not for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for the same time period).

Adult Services Manual (ASM) 9-1-2008

In this case the testimony from the Department's worker was that he spoke directly with the Appellant at the home call. He based his reductions on what she told him and his observation of her walking without use of an assistive device such as a cane or walker. He stated he did not notice an electric wheelchair in her home. The testimony further establishes the worker was newly assigned to the case.

The Appellant's representative stated she sees the Appellant use a walker and clutch furniture daily when walking inside the home. She further testified she has to set up the Appellant's medication for her. Furthermore, she has creams applied daily by a worker because she has psoriasis over 85% of her body, a very severe case. The lotion is applied to unreachable parts of her body. She said the Appellant was embarrassed to answer the questions freely with a man asking them. Additionally, the Appellant requires assistance using the toilet but won't allow it so she may soil her bed at night when no-one is there to assist her. The representative further asserted the Appellant is in early stages of dementia. This ALJ did look in the case file for corroborating medical confirmation of the dementia, however, did not find corroborating medical evidence of it. This ALJ did find evidence in the file the case had been withdrawn by a previous representative for the Appellant and then placed back on the docket following a telephone call the next day. This is not inconsistent with possible dementia and it is

taken into consideration by this ALJ. Additionally, this ALJ did find evidence in the file on the DHS 54A medical needs form the Appellant does have an electric scooter. This form is dated [redacted] and signed by the Appellant's medical provider. Her medical condition could have improved and/or changed since that time, however, this apparent discrepancy concerns this ALJ.

The Department's worker, on re-direct, stated the Appellant did not seem embarrassed to him at all during the assessment and she answered questions freely.

Given the Appellant's relatively advanced age, inconsistent position of whether or not to have a hearing and the discrepancy regarding her use of an assistive device for walking, this ALJ finds there is insufficient evidence the comprehensive assessment was adequate for the purpose of supporting the reductions made in this instance. Normally, after direct discussions with a beneficiary, reductions based upon their own statements are justified. In this instance, the possible dementia, advanced age and evidence of possible incomplete information has persuaded this ALJ another assessment is necessary.

Additionally, this ALJ is required to address the issue of lack of Advance Notice of the reduction. The evidence of record establishes a notice of reduction was printed [redacted], intending to effectuate a reduction in program benefits on [redacted] (retroactively). This is in violation of the Code of Federal Regulations requiring Advance Negative Action Notice be sent to allow a program participant to contest a reduction PRIOR to its implementation. The Department must correct this error because the DHS must implement the programs in accordance with the law and policy. 42 CFR Ch. IV Section 431.211 sets forth Advance Notice requirements for Medicaid beneficiaries. The State of Michigan Policy must adhere to them to avoid violation of the Code of Federal Regulations.

> The State of local agency must mail a notice at least 10 days before the date of action, except as permitted under section 431.213 and 431. 214 of this subpart.

The provisions contained in 42 CFR are expressed in the Administrative Rules promulgated in Michigan for the Department of Human Services Hearings, Appeals, and Declaratory Rulings. The pertinent Rule states:

> R. 400.902 Notice Of Negative Action
>
> Rule 902 (1) in cases of proposed action to discontinue, terminate, suspend, or reduce public assistance or services, he department shall mail a timely notice before a proposed change would be effective
>
> (1) Timely means that the notice is mailed at least 10 days before the actions would become effective. A notice shall include the following:…

The Rule continues, citing specifications of the contents of the notice and when the advance 10 day notice provisions do not apply, none of which are pertinent in this case. Furthermore, PAM 600 specifically addressed instances of when Advance Negative Action Notice must be given and what it is, consistent with the Administrative Rules and CFR discussed above.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has improperly reduced the Home Help Assistance payment of the Appellant without having made an adequate comprehensive assessment and without providing Advance Notice of the action.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department is hereby ordered to schedule a new comprehensive assessment. The Department is further ordered to correct the effective date of the [redacted], Advance Negative Action Notice to comply with the notice requirements.

_____

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/27/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.