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

,

Appellant
_______________________/

Docket No. 2009-34368 HHS
Case No.

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 . , appeared on her behalf.

, represented the Department. was present as a Department witness

ISSUE

Did the Department properly deny the Home Help Services application of 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 a Medicaid beneficiary who applied for Home Help Services from the Department of Human Services.
2. The Appellant resides in her own apartment. She is ambulatory, using a walker for assistance.
3. The Appellant suffers diabetes, hypertension and joint disease. She suffers numbness in her feet and hands.

4. The Appellant does not speak English.

5. The Department's worker had knowledge the Appellant does not speak English.

6. The Department's worker previously had the Appellant as a client for the Home Help Services program and had closed her case after determining she did not qualify for services.

7. The Department's worker made an unscheduled stop at the Appellant's residence . Following the unscheduled stop at her home, she denied program eligibility for the Home Help Services program to the Appellant.

8. The Department's worker had no communication with the Appellant. There was no English speaking person present at the unscheduled home call.

9. The Department sent Notice of the denial on or about .

10. The Appellant requested a formal, administrative hearing .

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.

<u>Time and Task</u>

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

Department policy addresses the need for supervision, monitoring or guiding below:

Services Not Covered By Home Help Services

Do **not** authorize HHS for the following:

- Supervising, monitoring, reminding, guiding 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;
- Services provided free of charge;

- Services provided by another resource at the same time;
- Transportation - Medical transportation policy and procedures are in Services Manual Item 211.
- Money management, e.g., power of attorney, representative payee;
- Medical services;
- Home delivered meals;
- Adult day care

Adult Services Manual (ASM) 9-1-2008

In this case the uncontested testimony is that the Appellant speaks little to no English. The Department's worker did not send a notice of the home call to the Appellant's home in advance of the day she stopped there. She testified she spoke with an English speaking person the morning of the home call to ask them to notify the Appellant she would be coming to her home. Allegedly, this person had made the referral to the Department on behalf of the Appellant. It is not known whether the Appellant was ever actually informed the Department's worker would be coming to her home that day or not. The Department's worker avoided answering the direct question from this ALJ how long she was present at the Appellant's home when she allegedly conducted a "comprehensive assessment" to determine program eligibility. She responded to that direct question by indicating she telephoned others in an attempt to reach an English speaker while present in the home and reiterating she had spoken with the referral source earlier that day. This ALJ took note the actual question had not been answered. The worker testified she observed the Appellant was dressed and appeared to be preparing her own breakfast. She determined nothing had changed in her circumstances and she was able to meet her own needs without assistance from those observations. The Department's representative asked the worker about the appearance of the home. She said it was neat and orderly. The worker was then asked (by this ALJ) if she had determined ranks for each of the functional areas assessed in the functional assessment. She testified she had not done so.

The Appellant's representative testified credibly that the Appellant's hands and feet are numb. She is aging and she can barely walk. She testified she is unable to do everything for herself "like she used to." She stated her family is assisting her some now.

This ALJ cannot find the Department's determination was based upon an adequate comprehensive assessment of the Appellant's abilities. The worker made an unscheduled stop at the Appellant's residence. This ALJ characterizes it such because the worker did not bother to send written notification of the date and time of the home call, at which a comprehensive assessment is to take place. So the worker arrives unannounced to the home of the Appellant, who she knows does not speak English. The Appellant has no opportunity to prepare for the home call, nor does she have the

ability to inform the worker of what her needs may be. After making two telephone calls in an attempt to contact an English speaking person, the worker allegedly writes down the Appellant's medications and leaves. The worker observes the Appellant is dressed. She states she "appears" to be making breakfast. These observations, coupled with two telephone calls are insufficient to constitute a comprehensive assessment. There is no evidence the worker was able to communicate with the Appellant about what her need for assistance may be. She did not, by her own admission, complete a functional assessment. Policy states she is to make a determination of need for assistance for each task listed. Payment is to be authorized for any task ranked 3 or greater. There is no explicit evidence in the record of how the worker determined program eligibility should be denied. How did she determine the Appellant requires no assistance sweeping, mopping and vacuuming her floors? How did she determine the Appellant is able to take the trash out without assistance? Where are her laundry facilities? Can she access them without physical assistance? Given the advanced age, numbness in the Appellant's hand and feet, these questions need to be asked and information obtained sufficient to make these determinations (and others) in order to conduct an adequate comprehensive assessment. The functional assessment is integral to a determination of whether a program applicant is eligible for the services or not. Program eligibility cannot possibly be determined with the known facts, without conducting a functional assessment and having the ability to actually communicate with the Applicant. This ALJ is dismayed the Department of Human Services condones the worker's conduct in this instance by allowing program eligibility denials to be issued with these facts and then determining it is appropriate to go to hearing to defend the denial without a functional assessment and no communication between the worker and applicant. This program applicant does suffer diabetes. The testimony regarding numbness in her hands and feet is consistent with the Appellant's known medical status and could very well affect her ability to perform her own Instrumental Activities of Daily Living and Activities of Daily Living. It is also possible the Appellant could perform her ADL's and IADL's without assistance, however, an adequate comprehensive assessment is necessary prior to denying program eligibility. Given that the worker did not even bother to conduct a functional assessment after stopping in at the Appellant's residence, this ALJ cannot find the Department's determination was based upon an adequate, sound comprehensive assessment.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has improperly denied program eligibility by failing to conduct a comprehensive assessment for the Appellant.

IT IS THEREFORE ORDERED that:

> The Department's decision is REVERSED. The Department is hereby ordered to schedule a comprehensive assessment, providing notice in writing to the Appellant of the date and time of the assessment. The Notice must be mailed at

least 10 days in advance of the date of the appointment to allow the Appellant opportunity to obtain assistance in having the English language Notice read and translated to her and opportunity to arrange assistance to be present at the home call to facilitate communication. This ALJ regrets having to render an order specifically directing the Department of Human Services to accommodate language barriers for program applicants.

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

cc:

Date Mailed: 10/29/2009

***** 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.