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

Docket No. 2010-13891 HHS
Case No. 16421925

[redacted]

Appellant
_____/

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] represented himself. The chore provider from his agency was present and testified on his behalf, [redacted]. [redacted], was also present.

[redacted] represented the Department. [redacted], was present as a Department witness. [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 a [redacted] year old Medicaid beneficiary who participates in the Home Help Services program.

2. The Appellant is diagnosed with Degenerative Disc Disorder, COPD and has a bulging disc. Additionally, he has bilateral lower extremity deep venous thrombosis. (Department exhibit A, Respondent exhibit A).

3. The Appellant resides in his own apartment. His home help services are provided through an agency.

4. The Appellant's case was scheduled for a review in [redacted] A Department worker completed a home call in conjunction with the review.

5. Following completion of the assessment during the home call, the Department's worker determined payment assistance for the tasks of meal preparation and laundry should be reduced.

6. The Department sent Notice of the reduction on or about [redacted] The Department incorrectly sent a Services Approval Notice rather than a negative action notice.

7. The Department made the reduction retroactive, indicating the effective date was [redacted]

8. 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

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 testimony from the Department's worker was that she interviewed the Appellant and his provider at the home call. The case had been transferred to her prior to the home call. She said the reductions were based upon information she learned at assessment and the provider logs. The logs indicate laundry is performed one (1) day per week, shopping one (1) day per week and meal preparation three (3) times per week, not daily. She further learned the Appellant drives his provider to the store to do the shopping. Finally, she testified she was told by the Appellant that he only takes the oxygen at night. Based upon the information she learned, she reduced meal preparation time and laundry time.

The Appellant requested a letter from his doctor be admitted into evidence. The Department representative objected to admission of the letter because it was dated [redacted], after the assessment and determination took place in [redacted] of [redacted]. It was asserted the letter contained information about "new" medical conditions which the Appellant would not have been afflicted with at the time of assessment. This ALJ did not sustain the Department's objection and allowed the letter in. It is relevant to illustrate the propriety of the comprehensive assessment conducted by the worker. There was no evidence in the letter that the Appellant's medical conditions were new or not afflicting him only a few weeks earlier, [redacted]. The letter is the written evidence, from the Appellant, attempting to illustrate that the Department worker was wrong when she reduced his assistance because he has medical reasons for requiring it. He is entitled to submit evidence tending to show the inadequacy of the comprehensive assessment and why it is inadequate.

The letter was read and considered by this ALJ. It does not state any of the conditions suffered by the Appellant are new or newly discovered. It does not indicate the Appellant is unable to care for himself in any respect he is not approved for assistance with except in the area of bathing. The letter asserts the Appellant needs help with bathing but does not state why his medical conditions render him unable to bath without assistance. Nor was it obvious to this ALJ. Notably, neither the Appellant himself, nor his provider, asserted directly that he is unable to bath without assistance. There is insufficient evidence of record to find the Appellant should be receiving payment assistance for bathing, none will be ordered.

The reductions for meal preparation are based upon good evidence that the provider is doing this three (3) or four (4) times per week. This tends to show the Appellant is able to participate in some meal preparation for himself and/or is heating up meals already prepared. Additionally again, there is nothing obvious about his medical condition that illustrates why he is physically unable to perform this task for himself. The fact of suffering an illness is an insufficient basis to approve payment assistance for Instrumental Activities of Daily Living. There must be an illustration of why a person is unable to prepare food to be approved for payment assistance for that task, and all others in this program. No such direct evidence was presented by the Appellant. Without substantial, material evidence to illustrate why he is physically unable to

prepare meals for himself, this ALJ cannot find the assistance level authorized inadequate. It will remain as ordered by the Department.

When considering laundry, it was stated by the Department's worker that he was approved for payment assistance for one (1) hour per week and that he is able to do some folding and putting away of his own clothing. The payment approved is only for one (1) hour per month, however. The worker did testify the rank for laundry should be a three (3), which would qualify the Appellant for payment assistance with that task. He lives alone, thus it would not be prorated with other members of the household. This ALJ finds one (1) hour per month of assistance with laundry is insufficient to aid with the task and accomplish the stated goal. The payment assistance for laundry must be adjusted to the level intended by the worker.

In reviewing the Notice sent the Appellant, this ALJ must address the error by the Department. Despite the fact that the Appellant's case was transferred to a different worker, the payment approval still represents a reduction. The former payment amount was just under [redacted] per month. The newly approved payment amount is just over [redacted], thus it is a reduction. This requires sending an Advance Negative Action Notice. The Advance Negative Action Notice has a pendency period that allows people to request hearing PRIOR to the implementation of a reduction. The Notice sent by the Department's worker in this case purportedly took effect in [redacted], prior to the comprehensive assessment even. This is not supported by Department Adult Home Services Policy and further more, expressly prohibited by the Code of Federal Regulations. Each is cited below:

Adult Services Manual (ASM 362) 12-1-2007, page 4 of 5 addresses the issue of termination of HHS payments:

> **TERMINATION OF HHS PAYMENTS**
>
> Suspend and/or terminate payments for HHS in **any** of the following circumstances:
>
> • The client fails to meet any of the eligibility requirements.
> • The client no longer wishes to receive HHS.
> • The client's provider fails to meet qualification criteria.
>
> When HHS are terminated or reduced for any reason, send a DHS- 1212 to the client advising of the negative action and explaining the reason. Continue the payment during the negative action period. Following the negative action period, complete a payment authorization on ASCAP to terminate payments.

> If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action.
>
> See Program Administrative Manual (PAM) 600 regarding interim benefits pending hearings and Services Requirements Manual (SRM) 181, Recoupment regarding following upheld hearing decisions.

Additionally, the Code of Federal Regulations, Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

> **§ 431.211 Advance notice.**
> The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.
>
> **§ 431.213 Exceptions from advance notice.**
> The agency may mail a notice not later than the date of action if—
> (a) The agency has factual information confirming the death of a recipient;
> (b) The agency receives a clear written statement signed by a recipient that—
> (1) He no longer wishes services; or
> (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
> (c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
> (d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);
> (e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
> (f) A change in the level of medical care is prescribed by the recipient's physician;
> (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or (h) The date of action will

occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

The Department was required to send an advanced negative action notice in this case. It did not. It was required to provide at least ten (10) days advanced notice. It did not. The Department error concerning the effective date must be corrected.

This ALJ finds the payment reduction for meal preparation is supported by competent, material and substantial evidence. The reduction for laundry is not sustained, as the payment approved is insufficient to accomplish the purpose it is authorized for.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has properly reduced payment assistance for the task of meal preparation. It is further found, the Department has improperly reduced the payment assistance for the task of laundry. The appropriate time for laundry assistance must be adjusted to four (4) hours per month, which is what the worker testified she intended to authorize for the Appellant. The Department must correct the Notice error by adjusting payments that may have been reduced for the months of [redacted], and [redacted] because the reduction was not authorized to be implemented prior to [redacted]

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED in PART and REVERSED in PART.

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

cc: [redacted]

Date Mailed: 3/10/2010

***** 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.