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. 2010-47738 HHS

[redacted],

Appellant

_____/

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]. [redacted] appeared on her own behalf. [redacted], Cousin, appeared as a witness for the Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker, appeared as a witness for the Department.

ISSUE

Did the Department properly reduce Home Help Services (HHS) 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 Medicaid beneficiary.

2. The Appellant is a [redacted] woman with diagnoses including nephrolithiasis, hypertension, asthma, diabetes, morbid obesity, congestive heart failure, diabetes mellitus, diabetic neuropathy, anxiety, depression, osteoarthritis, sleep apnea, lump in left breast, COPD, and lumbago. (Exhibit 1, pages 10 and 13-14)

3. On [redacted], the Appellant's Home Help Services (HHS) case was transferred to the [redacted] office in [redacted] due to the Appellant's move to [redacted] (Exhibit 1, page 13)

4. In [redacted], the new Adult Services Worker (ASW) assigned to the Appellant's case obtained a DHS 54-A Medical Needs form from the Appellant's physician. The physician indicated the Appellant had a

medical need for assistance with bathing, transferring, meal preparation, and shopping. (Exhibit 1, page 10)

5. Provider logs submitted for the months of [redacted] through [redacted] indicated the Appellant was receiving assistance 5 days per week. (Exhibit 1, pages 11-12)

6. Based on the information from provider logs and the DHS 54A Medical Needs form, the ASW decreased the Appellant's HHS payment. (ASW Testimony)

7. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating that her Home Help Services payments would be reduced to [redacted] per month effective [redacted] (Exhibit 1, pages 4-6)

8. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's Request for Hearing. (Exhibit 1, page 3).

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.

Program requirements are set forth in Adult Services Manual item 362, below:

COMPREHENSIVE ASSESSMENT

If the client appears eligible for independent living services, conduct a face-to face interview with the client in their home to assess the personal care needs. Complete the comprehensive assessment (DHS- 324) which is generated from the Adult Services Comprehensive Assessment Program (ASCAP).

SERVICE PLAN

Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the

assessed needs of the client. The ILS service plan is developed whenever an issue is identified in the comprehensive assessment.

CONTACTS

The worker must, at a minimum, have a face to face interview with the client **and** care provider, prior to case opening, then every six months, in the client's home, at review and redetermination.

Adult Services Manual (ASM 362) 12-1-2007, Page 3 of 5

Adult Services Manual item 363 addresses program procedures:

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (FIA-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 client in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the client'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 redetermination.
- 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 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 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 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.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 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.

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 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 same time period).

REVIEWS

ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan.

- Review of client satisfaction with the delivery of planned services.

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Annual Redetermination

Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

Requirements

- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.

- A new medical needs (DHS-54A) certification, if home help services are being paid.

  Note: The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.

- A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

Adult Services Manual (ASM 363) 9-1-2008, Pages 2-7 of 24

The Appellant's case was transferred to a new local DHS office on [redacted]. The transfer summary indicated that the case was due for a six month review that month. (Exhibit 1, page 13) The ASW who received the case in transfer reviewed the recent provider logs and noted that services were only being provided 5 days per week despite being authorized 7 days per week. (ASW Testimony and Exhibit 1, pages 11-12) The ASW also obtained a DHS 54-A Medical Needs form from the Appellant's physician. (Exhibit 1, page 10) Without completing a home visit or even contacting the Appellant, the ASW reduced the Appellant's HHS payments. She explained that the HHS hours for most activities were reduced to reflect the services being rendered only 5 days per week instead of 7 days per week. (See Exhibit 1, page 9) The ASW further explained that she reduced the laundry HHS hours because the Appellant had been receiving the HHS hours at the incontinent rate and the Appellant's doctor did not note incontinence on the DHS 54-A Medical needs form. (ASW Testimony)

The Appellant testified that her chore provider was helping her 5 days per week during the time period the logs covered, but was now providing services 7 days per week. She stated that the Department had the wrong doctor complete the DHS 54-A Medical Needs form and explained that she does not see this doctor all the time. The Appellant also testified she does have some incontinence.

It is understandable that the ASW would question services being provided 5 days per week instead of the authorized 7 days per week. However, this case was newly transferred to the ASW due to the Appellant's recent move and was due for a six month review. Without any knowledge of the Appellant or her circumstances, the ASW should have completed a comprehensive assessment or at the very least contacted the Appellant to discuss the discrepancy prior to making reductions to the time and task authorization. The above cited Department policy requires a review every six month and allows for reviews more often as necessary. Even if the Appellant's case had not been due for a six month review at the time of transfer, the discrepancy regarding how often services are provided would have been cause for an additional review.

The reduction to the HHS hours for laundry was based on a lack of medical documentation of incontinence. However, the DHS 54-A Medical Needs form does not specifically ask a doctor to indicate whether or not a patient is continent. (Exhibit 1, page 10) The ASW can not assume continence based on this form, but again could have clarified this concern at an assessment or even with a telephone call to the Appellant. Further, the ASW relied on policy from [redacted] addressing HHS laundry payment rates based on continence. (ASW Testimony) The Department policy regarding the IADL's, including laundry was updated in [redacted] and does not indicate documentation of incontinence is required to receive a higher payment. Adult Services Manual (ASM 363) 9-1-2008, Pages 3-4 of 24. The reductions to the Appellant's case can not be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly reduced the Appellant's HHS payments.

IT IS THEREFORE ORDERED THAT:

The Department's decision is REVERSED. The Appellant's HHS payment shall be returned to the previously authorized amount effective [redacted], including a retroactive payment if the reductions were implemented prior to the issuance of this hearing decision.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

[redacted]
Docket No. 2010-47738 HHS
Decision and Order

[redacted]

Date Mailed: 10/25/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules March 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 March 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.