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. 2010-49919 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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted] was present and represented herself. Her chore provider, [redacted], appeared as the Appellant's witness. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker (worker), and [redacted], General Services Program Manager, were present as Department witnesses.

ISSUE

Did the Department properly suspend Home Help Services (HHS) payments to the Appellant?

FINDINGS OF FACT

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

1. The Appellant is a female Medicaid beneficiary, who has been participating in the Adult HHS program.

2. The Appellant suffers from severe back and neck pain/spondylosis, lumbar spinal fusion, and a torn right wrist tendon. (Exhibit 1, page 15)

3. The Appellant informed the Department's worker at past comprehensive assessments that she is unable to perform certain Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) without assistance from another person. (Testimony of [redacted])

4. The Department authorized a payment of [redacted] per month so that the Appellant could have assistance with the following tasks: bathing, grooming, dressing, transferring, mobility, housework, laundry, shopping, and meal preparation. (Exhibit 1, page 11)

5. In [redacted], an elderly woman, [redacted], began living with the Appellant in the Appellant's home. (Testimony of [redacted]s) However, the Appellant did not advise her worker that [redacted] lived with her or that she was being paid to care for [redacted] (Testimony of [redacted]

6. In [redacted], the worker received an Adult Protective Services (APS) referral regarding [redacted]. Specifically, the worker was advised that the Appellant had allegedly tied [redacted] to her bed. That was the first time that the Appellant's worker learned that the Appellant was taking care of [redacted]. (Exhibit 1, page 13; Testimony o[redacted])

7. Based on the information received from the APS referral, the worker determined that the Appellant no longer needed HHS assistance. She notified the Appellant that her services were suspended on [redacted], and referred the matter to the Office of the Inspector General for a fraud investigation. The effective date of the action was [redacted]. (Exhibit 1, pages 5-8)

8. The Appellant appealed the suspension on [redacted] (Exhibit 1, page 4) A second hearing request was filed on [redacted]. (Exhibit 1, page 3)

9. On [redacted], the Appellant's HHS case was closed because there was no activity on the case for 90 days. (Testimony of [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 363 9-1-2008), page 7 of 24

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.

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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 363 9-1-2008), pages 2-5 of 24*

Policy establishes that the Department cannot pay for a chore provider if the beneficiary does not have a need for assistance. In this case, the worker learned that the Appellant was allegedly caring for an elderly woman, [redacted], who lived in the Appellant's home.

The worker testified that as a result of an APS referral, she received a letter from [redacted] a Social Worker a [redacted], where [redacted] was admitted, as well as a police report, both stating that the Appellant was [redacted] caregiver. (Exhibit 1, pages 16-23). In addition, the letter and report also indicated that the Appellant was able to ambulate in the hospital and come down a flight of stairs in her home without assistance. (Exhibit 1, pages 16-21) Moreover, the Appellant's granddaughter also stated to the police that the Appellant cared for [redacted] (Exhibit 1, pages 22-23)

The worker testified that this information indicated to her that the Appellant was caring for [redacted], when the Appellant claimed that she was unable to care for herself. The worker thereafter determined that the Appellant was not in need of physical assistance with the tasks of bathing, grooming, dressing, transferring, mobility, housework, laundry, shopping, and meal preparation. The Department sent a notice to the Appellant informing her that her benefits were being suspended. The Appellant appealed the proposed action. The worker conceded at the hearing that the Appellant's case should not have been closed and that she has no policy to support the retroactive suspension of the Appellant's benefits.

The Appellant testified that [redacted] did live with her, but she did not take care of [redacted]. She stated that she is not physically able to care for [redacted] or herself. She testified that she cannot bend her neck. The Appellant explained that her chore provider, her daughters, and her granddaughter took care of [redacted]. She stated that she took [redacted] into her home because [redacted] had nowhere else to go but a nursing home, and the Appellant had experience in caring for elderly Alzheimer patients. The Appellant further testified that the police officers just assumed that she was [redacted] caregiver, but they never asked her if she was. She further stated that the police reports are false and that her granddaughter did not state that the Appellant cared for [redacted]The Appellant further stated that the letter provided by the social worker was inaccurate. She stated that she had assistance from her daughter and son-in-law while walking in the hospital, and she had help from her granddaughter when she came down the stairs at her home. Finally, the Appellant admitted that she tied Sternhagen to her bed.

The Appellant's chore provider testified that she has assisted the Appellant since [redacted] She also testified that she helped take care of [redacted], along with the Appellant's daughter and granddaughter. She stated that she never saw the Appellant care for [redacted], but she was only in the home every other day. She further testified that someone was always with the Appellant and [redacted] during daytime hours, but they were alone at night. The Appellant's chore provider stated that the Appellant did tie [redacted] to her bed.

This Administrative Law Judge finds that the determination made by the Department's worker that the Appellant was not in need of physical assistance with the tasks of bathing, grooming, dressing, transferring, mobility, housework, laundry, shopping, and meal preparation was proper. The worker had information that the Appellant was caring for [redacted], that she was able to walk and come down stairs without assistance, and that she was capable of tying [redacted] to her bed. This information ended the Appellant's eligibility for payment assistance in the HHS program because it evidenced that she is capable of performing her own IADLS and ADLs.

However, the Department's retroactive suspension was not proper. Pursuant to the May 20, 2010, Advance Negative Action Notice, the Department implemented the suspension of the Appellant's case retroactive to May 1, 2010. 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)
>
> **§ 431.214 Notice in cases of probable fraud.**
> The agency may shorten the period of advance notice to 5 days before the date of action if—

> (a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
> (b) The facts have been verified, if possible, through secondary sources.

The [redacted] Advance Negative Action Notice issued by the Department clearly failed to provide the Appellant with the required advance notice of at least five days that her HHS payments would be suspended, as the effective date of the reduction was [redacted] (Exhibit 1, pages 5-8) None of the exceptions to the advance notice requirement were present in this case. Therefore, the Department should not have suspended the Appellant's HHS case any earlier than five days from the date of the Advance Negative Action Notice, [redacted]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly suspended the Appellant's HHS payments. However, its retroactive suspension was improper.

IT IS THEREFORE ORDERED that:

> The Department's decision is PARTIALLY AFFIRMED and PARTIALLY REVERSED. The suspension is affirmed, but it cannot be made effective any earlier than five days from [redacted], the date of the Advance Negative Action Notice.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/23/2010

***** 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.