STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2010-51265 HHS
Case No. 88998163

[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], the Appellant was represented by [redacted].

[redacted], represented the Department of Community Health. [redacted], was present on behalf of the Department. [redacted], was present on behalf of the Department.

ISSUE

Did the Department properly reduce the 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 [redacted] Medicaid beneficiary who participates in the Home Help Services (HHS) program.
2. The Appellant resides with [redacted].
3. The Appellant is wheelchair bound, suffering right-sided paralysis as a result of a stroke.
4. The Appellant also suffers Crohn's disease, Paget's disease, high blood pressure and osteo-arthritis.

5. The Appellant receives payment assistance for the tasks of bathing, grooming, dressing, transferring, eating, mobility, medication, housework, laundry, shopping, and meal preparation.

6. The Department conducted an annual case review of the Appellant's HHS case on [redacted].

7. The Appellant's payment assistance for the tasks of housework, laundry, shopping and meal preparation, were pro-rated after the Department's worker learned she was residing with [redacted].

8. The Appellant has a functional rank of 5 for laundry.

9. The Appellant was approved for 1 hour of laundry assistance per month following the comprehensive assessment completed by the Department's worker.

10. The Appellant is incontinent. (uncontested)

11. The Appellant receives physical assistance with toileting multiple times per day. (uncontested testimony from [redacted])

12. The Appellant receives and uses incontinence supplies provided through Medicaid. (uncontested)

13. The Appellant frequently soils her bed linens and clothing due to her medical condition. (uncontested testimony from [redacted])

14. The Department sent the Appellant an Advance Negative Action Notice [redacted]. The effective date was [redacted].

15. The Appellant sent a hearing request, which was received by the Department of Community Health on [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.

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

> **GENERAL SERVICES REQUIREMENTS** The client must sign an Adult Services Application (DHS-390) to receive ILS. An authorized representative or other person acting for the client may sign the DHS-390 if the client:
>
> - Is incapacitated, **or**
> - Has been determined incompetent, **or**
> - Has an emergency. A client unable to write may sign with an "X", witnessed by one other person (e.g., relative or department staff). Adult services workers must not sign the services application (DHS-390) for the client. Eligibility must be determined within 45 days of the signature date on the DHS-390.
>
> **Note:** ASSIST (Automated Social Services Information and Support) requires a disposition within 30 days of the registered request. See ASSIST User Manual (AUM) 150-7/8. The DHS-390 is valid indefinitely unless the case is closed for more than 90 days.
>
> **ELIGIBILITY CRITERIA**
>
> **Independent Living Services** The following **nonpayment** related independent living services are available to any person upon request **regardless** of income or resources:
> - Counseling.
> - Education and training.
> - Employment.
> - Family planning.
> - Health related.
> - Homemaking.
> - Housing.
> - Information and referral.
> - Money management.
> - Protection (For adults in need of a conservator or a guardian, but who are not in any immediate need for protective service intervention.)
>
> **Home Help Services (HHS) Payment** related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should

be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:

- The client must be eligible for Medicaid.
- Have a scope of coverage of:
  - 1F or 2F,
  - 1D or 1K, (Freedom to Work), **or**
  - 1T (Healthy Kids Expansion).
- The client must have a need for service, based on
  - Client choice, **and**
  - Comprehensive Assessment (DHS-324) indicating a functional limitation of level 3 or greater in an ADL or IADL.
- Medical Needs (DHS-54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:
  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

ASM 362, 12-1-2007

Manual Item 363 addresses what a comprehensive assessment consists of, as well as other program procedures.

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.

A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment. The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy

Service planning is person-centered and strength-based. Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the caregiver, if applicable.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services, and
- Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

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.** (emphasis added by ALJ)
- 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).

Good Practices Service plan development practices will include the use of the following skills:

- **Listen actively** to the client.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for **congruency** between case assessment and service plan.
- Provide the necessary supports to **assist** clients **in applying for resources**.
- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.
- **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

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.

Documentation

Case documentation for all reviews should include:

- Update the **"Disposition"** module in ASCAP.
- Generate the CIMS Services Transaction (DHS-5S) from **forms** in **ASCAP**.
- Review of **all** ASCAP modules **and** update information as needed.
- Enter a brief statement of the nature of the contact and who was present in **Contact Details** module of ASCAP.

- Record expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- Record summary of progress in service plan by clicking on **Insert New Progress Statement in General Narrative** button, found in any of the **Service Plan** tabs. **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.

ELIGIBILITY FOR HOME HELP SERVICES
Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid(MA)
Verify the client's Medicaid/Medical aid status. The client may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**

- MA deductible obligation has been met. The client must have a scope of coverage of:

  • 1F or 2F, **or**
  • 1D or 1K (Freedom to Work), **or**
  • 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rate by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

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

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client 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.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form. The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional 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 client and/or medical professional. If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.

Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.

Payment for Medical Exams:
The Medicaid card is to be used to pay for medical professional charges for examinations or tests to certify the client's need for services and for completing the DHS-54A for MA recipients. Use the Examination Authorization/Invoice for Services (DHS-93) to pay for professional charges for non-MA clients. Payment is limited to the medical procedures and tests necessary to certify the client's need for home help services. See SRM 234, Diagnostic Fee Schedule.

Medical Review Team (MRT)
If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT evaluation is needed. The local office designee will forward the packet to the regional Disability Determination Services (DDS) MRT. The MRT will make a determination and return the forms. See L-letter 00-130, June 20, 2000. The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.

Services not Covered by Home Help Services
Do **not** authorize HHS payment 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 - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.
- Money management, e.g., power of attorney, representative payee;
- Medical services;

- Home delivered meals;
- Adult day care.

Note: If it appears the client's primary need is for adult foster care (AFC) or foster care is being provided without a license, the case should be referred to the local AFC licensing consultant.

ASM 363, 9-1-2008

In this case the Department conducted an annual review of the Appellant's Home Help Services case. It took one action following the review, to pro-rate payment assistance for instrumental activities of daily living. The Department contends the action taken is supported by, in fact, required by policy. Even a cursory review of the evidence in the record cannot support the Department's action in this case.

The uncontested written evidence of record establishes the Appellant has a functional rank of 5 for the task of laundry. According to the Adult Services Policy manual, a functional rank of 5 evidences the beneficiary does not participate in the task at all and is fully dependent upon others for its completion. In this case, this rank is borne out by the evidence of the Appellant's medical condition, right sided paralysis, wheelchair dependency and inability to even feed herself. The rank is credible. Page 9 of the Department's evidentiary packet indicates the worker authorized a total of 1 hour per month of time to accomplish the task of laundry performance on behalf of the Appellant. This is so astonishingly inadequate; this ALJ can only believe it was an error. An error, however, that even a cursory review of the file would have uncovered it. It is apparent neither the worker, her supervisor nor the appeals and review officer sought to determine if the Appellant's needs had been properly and adequately addressed prior to hearing. This ALJ cannot find the Department's action to reduce payment assistance for laundry to 1 hour per month is supported by any policy in the adult services manual. Nor could this ALJ find the Department's worker conducted an adequate comprehensive assessment with the evidence in the record. The evidence of record can only support a finding the worker conducted an inadequate review, obtaining insufficient knowledge of the Appellant's circumstances and needs to correctly determine the correct functional ranks and authorize payment assistance. For this reason I cannot uphold the Department's action.

The Appellant's [redacted] provided credible testimony concerning the Appellant's needs for hands on assistance with her activities of daily living and instrumental activities of daily living, including assistance with toileting due to incontinence. Her testimony is corroborated by the evidence in the Department's records indicating that the Appellant suffers right sided paralysis following a stroke, chrohn's disease, Pagets disease and osteoarthritis, among other ailments. It is noted in the brief notes justifying the functional ranks the Appellant is unable to feed herself following her second stroke. The only other comment specifically relating the Appellant's physical limitations and/or abilities is that she is unable to walk and needs help transferring too. Given the scintilla of information in evidence, this ALJ was alerted to the fact that the case was not

monitored for congruency of service need and payment authorization. The functional ranks indicate the Appellant is 1 for continence, meaning she is not incontinent. The uncontested evidence of record indicates she is incontinent and that this is not a new condition. The functional ranks further indicate she is 1 for toileting. However, she is not independent in her toileting. The credible, uncontested evidence provided by her [redacted] is that she is requires hands on assistance with this task. This is corroborated by the fact that she has incontinence supplies delivered to her home and her medical needs form indicates she requires assistance with toileting. Furthermore, it says right in the file she is even unable to feed herself following a second stroke. There is no evidence in the file reconciling the fact that she is known to be unable to feed herself, is authorized to receive payment assistance for this task, yet ranked as independent for toileting. There may be some scenario under which a person may be unable to feed him or herself, yet be fully independent in toileting, but this ALJ could not surmize it without some evidence.

This ALJ sought to reconcile how it a functional rank of 1 for toileting was determined to be correct at the assessment conducted [redacted]. The Department provided no evidence to support a finding that the comprehensive assessment was adequate with respect to this need. In fact, this ALJ had trouble obtaining direct answers to the direct questions asked of the Department witness. This ALJ asked "was the issue of incontinence discussed? The answer provided is convoluted. The witness stated "I don't see where this was a problem at that time, no". What is that intended to mean? Earlier the worker had testified, in response to this ALJ's questions, she had "gone through all the tasks". So did she specifically ask the Appellant if she was incontinent or not? This ALJ cannot find with any degree of certainty this issue was explicitly addressed. The witness also testified she did not know of the Appellant's incontinence at the time of review and asserted she was not told she required assistance with toileting.

This ALJ believes the worker did not know the Appellant is incontinent, based upon her statement at hearing that she did not know and contrary to her assertion that she "went through all the tasks". It cannot be believed she "went through all the tasks" when practically the first statement from the Appellant's [redacted] is that her [redacted] has incontinence issues that require a lot of assistance and performance of laundry due to constant soiling of clothing and bed linens. The Department's witness reiterated that she had not been informed at the comprehensive review that additional services were needed, however, this only serves to corroborate the claim from the Appellant's [redacted] that she thought the worker knew her [redacted] is incontinent. Furthermore, there is no evidence in the record either the Appellant or her [redacted] were ever informed of the specific tasks she was authorized to receive payment assistance with or potentially eligible for payment assistance with. The Notices mailed by the Department do not specifically inform the beneficiary of which tasks are payment eligible and approved unless the worker explicitly types it. Finally, the Adult Services manual policy places the responsibility to ascertain the potential beneficiary's needs on the worker, who is to conduct a comprehensive assessment at the annual review. She is to monitor

the case for congruency and ascertain what the clients needs are. Here, she had notice this beneficiary is unable to feed herself and not ambulatory. Why then didn't she know how she is toileted? It is her responsibility not only to ask specific enough questions to obtain the information needed to make accurate determinations but ensure the needs are addressed by the services plan. Obviously, in this case she failed to do either. This ALJ cannot find support in Policy for the idea that the beneficiary bears responsibility for failing to initiate a detailed conversation about how toileting is accomplished during a comprehensive assessment. The policy places the responsibility to conduct a comprehensive assessment on the worker.

The Department sought to avoid developing the record regarding the sufficiency of the comprehensive assessment by pointing out the only action taken and addressed in the hearing request is the number of people in the home and pro-rating. This is despite the uncontested, credible evidence that the client is incontinent and receiving extensive assistance with toileting. The uncontested testimony is that she has used incontinent supplies for number of years. Rather than offer to remedy the obvious oversight, the Department seeks to limit the scope of the hearing to the action addressed in the Notice. While the Department's Notice may only acknowledge one action (pro-rating the IADL's), other actions were taken. An annual review was conducted. A comprehensive assessment completed. Functional ranks were assigned. Payment was authorized for each task. Furthermore, the Department has no interest in denying payment assistance to a qualified beneficiary for a task she actually requires assistance with and is eligible for under the Policy. It is mystifying to this ALJ why anyone in MDCH or DHS would seek to deprive a qualified beneficiary of a needed benefit, including adequate time for laundry services.

This ALJ reviewed all the evidence of record. The evidence cannot support a finding that the Department's action is in accord with the Policy. Not only does not it support a finding the comprehensive assessment is adequate, it supports a finding the time authorized for laundry is inadequate. Here, there is credible evidence of incontinence and frequent soiling of bed linens and clothing combined with a functional rank of 5 for laundry services. It is appropriate to pro-rate the IADL's in most circumstances, but not in this case for laundry. It is evident that the maximum number of hours allowed in Policy is required to reasonably achieve the task of laundry in this case, thus the Department's action for this task cannot be sustained. Furthermore, it is evident the comprehensive assessment is inadequate to be found reliable. It must be rescheduled and completed again. The worker assigned to complete the comprehensive assessment must specifically determine the correct functional rank for incontinence and toileting for this beneficiary at the comprehensive assessment.

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 Home Help Services payment.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department is hereby ordered to restore the payment assistance for laundry to the level prior to its action of [redacted]. Furthermore, the Department is ordered to complete a new comprehensive assessment to specifically include toileting. Should the Department authorize payment assistance for toileting as a result of the comprehensive assessment, payment must be authorized from no later than 10 days following the mailing of this Decision and Order.

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

cc: [redacted]

Date Mailed: 11/4/2010

***** 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.