**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-5383 HHS
Case No. [redacted]

## 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]dgers appeared on her own behalf. [redacted], Appeals and Review Officer, represented the Department. [redacted] Adult Services Worker, and [redacted], Adult Services Supervisor, were present as Department witnesses.

## 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 was receiving Adult Home Help Services.

2. The Appellant has been diagnosed with heart condition, high blood pressure and arthritis in her spine and hips. (Exhibit 1, page 13)

3. The Appellant's chore provider changed in [redacted]. (Exhibit 1, page 11)

4. On [redacted], an Adult Services Worker conducted an in home assessment with the Appellant for continuing eligibility for Home Help Services. (Exhibit 1, page 4)

5. On [redacted], the Adult Services Worker conducted a face to face meeting with the new chore provider at the Department office. (Exhibit 1, page 4)

6. As a result of the information gathered from the Appellant and from the chore provider, the Adult Services Worker determined that the Appellant was only eligible for 7 hours and 30 minutes per month of continuing Home Help Services. (Exhibit 1, page 10)

7. On [redacted], the Department issued a Services Approval Notice to the Appellant indicating that her Home Help Services payments would be [redacted], effective [redacted]. (Exhibit 1, pages 4-6)

8. The Appellant requested a formal, administrative hearing [redacted] (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 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.

Adult Services Manual (ASM 363) 9-1-2008, pages 2-5 of 24 addresses the issue of assessment:

### 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).
>
> Adult Services Manual (ASM 363) 9-1-2008, Pages 2-5 of 24

Finally the Code of Federal Regulation 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)

On [redacted], the Adult Services Worker (worker) completed a home visit as part of an HHS comprehensive assessment for redetermination in accordance with Department policy. The worker testified that the Appellant's chore provider had quit, however, his

father would take over and become the Appellant's new chore provider. The worker testified that on [redacted] he met with the new chore provider who stated he would only assist the Appellant 3 days per week with the tasks of housework, shopping, laundry and meal preparation. The worker explained that she therefore only approved HHS hours for the times and tasks the new chore provider indicated he was willing and able to perform. The worker explained that the hours authorized for these tasks were then reduced by 1/3, in accordance with the Department policy on proration, because Appellant's [redacted] live in the Appellant's home.

The Appellant disagrees with the reduction of the HHS payments from [redacted] to [redacted]. The Appellant testified that there was no period where she was without a provider because her new chore provider started as soon as his son, the prior provider, quit. The Appellant testified that her new provider does assist her with all needed tasks, not just housework, laundry, shopping, and meal preparation. The Appellant also stated that her son was incarcerated in December 2009 and therefore no longer lives in the home.

The Department properly considered the household composition as part of the assessment for continuing HHS payments. Proration is appropriate for the tasks of housework, laundry, shopping and meal preparation when there is a shared household. However, the worker did not complete the other aspects of the assessment in accordance with the above cited Department policy.

The HHS assessment should have determined the Appellant's abilities and the level of assistance she needs. The HHS assessment should not have been based on what the proposed provider stated he was willing and able to do. The rankings assigned to the Appellant and time and task authorizations made by the worker are not consistent with the level of assistance the Appellant needs. For example, the worker ranked the Appellant as a level 1 and did not authorize and HHS hours for the activities of bathing, transferring, and mobility. However, the worker noted that the Appellant needs help in and out of the tub for bathing, needs a boost for transferring due to her weak back, and that she is occasionally unsteady for mobility. (Exhibit 1, pages 9-10)

The Adult Services Supervisor present at the hearing also testified that before cuts to the Appellant's HHS benefits were made due to the chore provider not being willing or able to perform some tasks, the Appellant should have been contacted and given the opportunity to choose a new provider or a second provider to meet her needs. The worker erred by removing HHS tasks based on the providers statements without further discussions with the Appellant.

The worker also failed to send advance notice of the drastic reduction in payments she was implementing. The Appellant was previously receiving [redacted] per month in HHS payments. (Exhibit 1, page 12) The contact history shows that the only notice sent to the Appellant was a Services and Payment Approval Notice sent on [redacted], [redacted] which stated that payments were approved for [redacted] per month effective [redacted]. (Exhibit 1, pages 4-6) This is not advance notice of a negative action, and it is a

retroactive cut to the Appellant's benefit. The worker sent the Notice in violation of the Code of Federal Regulations as none of the exceptions to the 10 day rule apply in this case. It was Department error to enact the cuts without conducting a proper comprehensive assessment and without proper notice of the reduction.

A new comprehensive assessment is needed given the recent change in household composition and the Appellant's testimony that her provider does assist with tasks beyond housekeeping shopping, laundry and meal preparation. This assessment should determine the Appellant's abilities and level of services she needs. If the Appellant should require assistance with tasks that her current provider is unwilling or unable to perform, the Department should discuss this with the Appellant so she can decide if she would like to choose a new provider or have a second provider for the additional tasks.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has did not properly reduce home help assistance payments for the Appellant.

**IT IS THEREFORE ORDERED** that:

The Department's decision is REVERSED. The Department is hereby ordered to reinstate the Appellant's HHS payments to the amount authorized prior to the September 17, 2009 Services and Payment Approval Notice, if it has not already done so.

Furthermore, the Department is ordered to conduct a new comprehensive assessment of the Appellant's abilities and assistance needs.

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

cc: [redacted]

Date Mailed: 1/27/2010

***** 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.