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

[redacted]

Appellant
_____/

Docket No. 2010-55763 HHS
Case No. 30528734

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's [redacted], represented the Appellant. [redacted], represented the Department. [redacted] (worker), was present as the Department's witness.

ISSUE

Did the Department properly reduce the Appellant's Home Help Services (HHS) payments?

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 [redacted] Medicaid beneficiary who was receiving Adult HHS. (Testimony of Williams)

2. The Appellant has been diagnosed with multiple medical conditions, including diabetes, heart problems, hypertension, and incontinence. (Exhibit 1, page 13)

3. In [redacted], a Medicaid audit was conducted and it was determined that the Appellant's HHS payment was in excess of what was justified. (Testimony of [redacted])

4. As a result of the audit, the worker scheduled and conducted a home visit on [redacted], to determine her continuing need for HHS. (Exhibit 1, pages 9-10)

5. However, on [redacted], before the home visit was conducted, the worker issued an Advance Negative Action Notice, informing the Appellant that her HHS payment would be reduced to [redacted] per month because "[t]he care cost exceeds the justification of [functional] abilities." (Exhibit 1, pages 5-7)

6. More specifically, the worker reduced the hours provided in the Appellant's chore grant for the following tasks: bathing, grooming, dressing, medication, toileting, mobility, and transferring. (Exhibit 1, pages 11-12)

7. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's Request for Hearing, contesting the reduction of her HHS payment. (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.

The purpose of HHS is 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.

The 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 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)

In [redacted], after a Medicaid audit, the worker scheduled and conducted a home visit for purposes of assessing the Appellant's continuing need for HHS. However, before the home visit, the worker issued an Advance Negative Action, reducing the Appellant's HHS payment from $[redacted] to $[redacted], effective [redacted]. More specifically, he reduced the tasks of bathing, grooming, dressing, medication, toileting, mobility, and transferring. He stated that the reductions were made to bring the case into compliance with the audit. He conceded that he made the reductions before he conducted the home visit with the Appellant. He further conceded that at the home visit, he did not ask the Appellant about any specific tasks or her need for assistance; rather, he discussed with her the reductions that he had already made. In fact, the worker testified that, in the last two years, he has never asked the Appellant about the tasks and her specific needs. He further testified that the Appellant told him that she needed the money to pay for her prescription medications.

The Appellant's [redacted] disagrees with the reduction of the HHS payments. She testified that, at the home visit, she attempted to explain to the worker the Appellant's deteriorating medical condition.

Here, the worker did not complete an assessment in accordance with Department policy. During the HHS assessment, the worker should have determined the Appellant's abilities and the level of assistance she needs. The worker admitted that he did not ask any specific questions about the tasks or the Appellant's specific needs. He further admitted that he made the reductions before he even conducted the home visit.

The worker also failed to provide advance notice of the drastic reduction in payments he was implementing. The Appellant was previously receiving $[redacted] per month in HHS payments. And the Advance Negative Action Notice that was sent to the Appellant on [redacted], had an effective date of [redacted]. This is not proper advance notice of a negative action. The Department cannot retroactively reduce an HHS payment. The reduction should not have been implemented any earlier than 10 days from the notice, or [redacted]. It was Department error to enact the cuts without conducting a proper comprehensive assessment and without proper notice of the reduction.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department's reduction of the Appellant's HHS payments was improper.

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 before the [redacted], Advance Negative Action Notice.

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

Kristin M. Heyse
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/10/2011

***** 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.