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

IN THE MATTER OF:

[redacted],

Docket No. 2011-49397 HHS
Case No. [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], Appellant, appeared and testified. [redacted], Appellant's Home Help Provider, 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 the Appellant's Home Help Services (HHS) payments?

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.

2. The Appellant has been diagnosed with Hypertension, Rheumatoid Arthritis, Hiatial Hernia, and High Cholesterol. (Exhibit 1, page 59)

3. The Appellant resides alone in her [redacted] apartment.

4. The Appellant has a valid Michigan Diver's License and is able to drive her car into the community for shopping and medical appointments.

5. The Appellant was receiving Home Help Services (HHS) for assistance with bathing, grooming, dressing, toileting, medication, housework, laundry, shopping, and meal preparation.

6. On [redacted], the Appellant's HHS provider telephoned [redacted], the Appellant's Adult Services Worker, and informed [redacted] that she

was not assisting the Appellant with bathing, dressing, or toileting because the Appellant was able to perform those tasks independently. The Appellant's HHS provider also indicated that the Appellant shopped for her own food and medications.

7. On [redacted] sent the Appellant an Advance Action Notice which informed the Appellant that effective [redacted], the Appellant's HHS would be reduced to [redacted] per month.

8. On [redacted], [redacted] completed an in home HHS assessment on the Appellant. [redacted] determined that the Appellant had a medical need for [redacted] or 51 hours 44 minutes per month of HHS.

9. On [redacted], the Appellant was sent a Service Authorization Notice informing the Appellant that effective [redacted], she was approved for 51 hours 44 minutes per month of HHS.

10. On [redacted], the Michigan Administrative Hearing System received the Appellant's request for hearing.

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.

Adult Services Manual (ASM 363, 9-1-08), 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.
- 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).

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.

Adult Services Manual (ASM) 363, 9-1-2008, Pages 2-15 of 24

The evidence presented shows that on [redacted], the Appellant's Adult Services Worker, received a telephone call from [redacted] the Appellant's HHS provider. [redacted] informed [redacted] that the Appellant was performing all of her Activities of Daily Living (ADLs) and [redacted] was not helping the Appellant with bathing, dressing, or toileting. [redacted] also informed [redacted] that the Appellant was able to drive the Appellant's car to complete her own shopping and obtain medications. Exhibit 1, p. 53. [redacted] testified that, based on this information, she reviewed the Appellant's HHS authorization and removed hours for bathing, dressing, grooming, toileting and shopping for food and medications. The Appellant's authorized HHS hours were reduced to 44 hours 8 minutes or [redacted] per month. [redacted] then issued a [redacted], Advance Negative Notice which informed the Appellant that effective [redacted], the Appellant's HHS would be reduced to [redacted] per month.

The evidence also shows that subsequently on [redacted] completed a new HHS assessment for the Appellant. [redacted] determined in the [redacted], assessment that the Appellant had a medical need for [redacted] or 51 hours 44 minutes per month of HHS. The [redacted], assessment included hours for bathing, grooming, dressing, shopping, medication, housework, laundry, and meal preparation. The Appellant is appealing the [redacted], reduction and the [redacted], HHS assessment.

The Appellant testified that her HHS were reduced in [redacted], without advance notice and that neither the [redacted] reduction nor the [redacted] HHS assessment amounts adequately meet her medical need for services. There is no dispute that the Appellant has a medical need for some HHS. The [redacted], Medical Needs form shows that the Appellant's physician certified that the Appellant has a medical need for HHS due to

diagnosed condition of Rheumatoid Arthritis, cervical and lumbar radiculopathy. Additional medical documentation was provided which shows that the Appellant has some physical restrictions in range of motion and lifting.

The medical information provided, while informative, is not controlling. Department policy at ASM 363 provides that a…"medical professional certifies that the client's need for services is related to an existing medical condition. The medical profession does not prescribe or authorize personal care services." See ASM 363, p. 9 of 24. Department policy also provides that "the adult services worker is responsible for determining the necessity and level of need for HHS based on client choice, a completed comprehensive assessment and determination of the client's need for personal care services and verification of the clients medical needs by a Medicaid enrolled medical professional." See ASM 363, p. 9 of 24.

Ms. White, the Appellant's Adult Services Worker, testified that on [redacted], she completed a comprehensive assessment of the Appellant's need for HHS and determined that Appellant had a medical need for 51 hours 44 minutes or [redacted] per month of HHS. [redacted] testified that when completing the assessment she considered that Appellant's diagnosed medical conditions and related physical limitations and considered the information obtained from the Appellant and her provider. [redacted], also during the in home assessment, made observations of the Appellant's ability to ambulate, lift, and carry items and perform simple tasks. [redacted] testified that the amount of HHS authorized after the [redacted] assessment would meet the Appellant's medical need for services. I agree.

The Appellant testified that she believes that the [redacted] assessment does not include enough hours for all tasks. However the Appellant did not provide evidence to support her conclusion. The Appellant did not provide credible evidence regarding why she needed additional time for each task considered by [redacted]. The Appellant testified that she does not agree with the entire assessment because her medical condition and limitations, as documented by her medical records, require more HHS hours in all tasks.

The evidence shows, that despite the Appellant's medical condition, the Appellant has a valid driver's license and is able to drive to medical appointments and shop. If the Appellant has the ability to walk to and from her car, and safely drive the car in and around her community for shopping and errands, it is not clear why she would need hands on assistance with her ADLs at a higher level than determined by [redacted]. The medical documentation provided is evidence of the Appellant's physical limitations but according to applicable HHS policy, [redacted] assessment and not the Appellant's physician's opinion is controlling. The Appellant failed to submit credible evidence that [redacted] assessment fails to meet the Appellant's medical need for HHS.

The evidence presented shows that on [redacted], the Department issued an Advance Negative Action Notice which reduced the Appellant's authorized HHS to [redacted] effective [redacted]. The Department's actions incorrectly made the HHS reductions retroactive to [redacted]. (Exhibit 1, p. 8) The Code of Federal

Regulations addresses an 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 10 days that her HHS payments would be reduced. The effective date of the reduction was [redacted] 8 days before the [redacted], mailing date. (Exhibit 1, page 8). None of the exceptions to the advance notice requirement were present in this case. Therefore, the Department should not have made the effective date for the Appellant's Home Help Services reductions any earlier than 10 days from the date of the Advance Negative Action Notice.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department did not properly reduce the Appellant's HHS payments for the period [redacted] to [redacted]. The Department properly determined the Appellant's HHS hours in the [redacted], assessment.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is PARTIALLY REVERSED. The reduction of HHS hours for the period [redacted] to [redacted], is REVERSED. The authorized HHS hours for this period should be returned to the pre [redacted], level until the effective date of the [redacted] assessment. The HHS hours authorized in the [redacted] assessment are AFFIRMED.

Martin D. Snider
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/23/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.