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. 2011-50393 HHS
Case No. [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 begun [redacted]. For good cause, it was continued [redacted], and completed. The Appellant was represented by her daughter, [redacted] at hearing.

[redacted], Appeals and Review Officer for the Department of Community Health, represented the Department. [redacted], Supervisor for the Adult Services Program at the Department of Human Services, was present on behalf of the Department. [redacted], contact worker for the Adult Services program, was present on behalf of the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services case?

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 Medicaid beneficiary who has been participating in the Adult Home Help Services program.

2. The Appellant is [redacted] years old. She suffers senile dementia. (uncontested)

3. The Appellant authorized her daughter to represent her at hearing on the signed request for hearing form.

4. Narrative notes contained in the Appellant's file indicate on [redacted], the DHS contact worker who was not the regularly assigned worker in the case accepted a telephone call from the Appellant's daughter/provider in the Home Help program. (testimony of worker)

5. The Appellant's daughter informed the worker she required more compensation for the assistance she was providing her mother. (narrative notes)

6. The Department's contact worker asked if the Appellant's medical condition had changed and was informed it had not changed. (testimony of worker)

7. The contact worker informed the provider no increase in payment was necessary. (Department Exhibit B, page 4) The Department's worker noted the provider wanted an increase in pay or increase in hours.

8. After the provider was informed no increase was needed she told the contact worker to close the case because it was not worth her time. (Department Exhibit B, page 4)

9. The Department's contact worker asked for the Appellant to indicate she wanted her case closed. The Department reported the Appellant came to the phone and stated "please close."

10. On [redacted], the same day as the contact telephone call, the Department mailed an Advance Negative Action Notice to the Appellant informing her the case was closed. The reason cited was the request of client and provider due to insufficient hours.

11. On [redacted], the Appellant's daughter sent a request for hearing to the Department of Human Services requesting a hearing on her mother's behalf. It was date stamped received at the Department of Human Services [redacted].

12. The Department of Community Health received the hearing request [redacted], and thereafter, on [redacted], sent a letter to the Appellant (in English) informing her signature was absent from the hearing request form and asking she sign and return it within 30 days. The letter was returned [redacted], signed by the Appellant.

13. The Department sought dismissal of the instant matter on the asserted grounds that the hearing request was not timely made. This request was denied by this ALJ.

14. Narrative notes in the evidentiary record establish the Appellant was reportedly incontinent dating to at least [redacted]. No action

was taken by the Department as concerns the reported change in medical condition.

15. The Department failed to change the Appellant's functional rank for toileting to reflect the information provided that she is incontinent.

16. The Department did not authorize payment assistance for toileting assistance, despite its own notation the Appellant requires assistance wiping following toileting dating back to at least [redacted].

17. The Appellant's assigned Adult Services Worker was reportedly on an extended medical leave during the time period during which payment error was continuing. The Appellant and her provider were unable to reach her.

18. The case file reflected the Department had knowledge of the Appellant's memory problems and confusion. (Department Exhibit A, narrative notes)

19. The Department's contact worker had access to the Appellant's case records via computer at time of telephone contact in [redacted]. (testimony of worker)

20. The Department's contact worker did not consult supervision following the telephone contact and prior to issuing the Negative Action Notice on the same day.

21. The Department's worker did not have the Appellant's consent to discuss her HHS case with her provider prior to participating in the conversation.

22. The Department did not have the authority to accept the provider's statement that she wanted the case closed and act on it.

23. There is no evidence the Department obtained a knowing and voluntary request for case closure from the Appellant, who suffers dementia.

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) 9-1-2008

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.

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).

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
TERMINATION OF HHS PAYMENTS

Suspend and/or terminate payments for HHS in **any** of the following circumstances:

- The client fails to meet any of the eligibility requirements.
- The client no longer wishes to receive HHS.
- The client's provider fails to meet qualification criteria.

When HHS are terminated or reduced for any reason, send a DHS-1212 to the client advising of the negative action and explaining the reason.

Continue the payment during the negative action period. Following the negative action period, complete a payment authorization on ASCAP to terminate payments. If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action.

See Program Administrative Manual (PAM) 600 regarding interim benefits pending hearings and Services Requirements Manual (SRM) 181, Recoupment regarding following upheld hearing decisions.

Adult Services Manual (ASM) 9-1-2008

The Department terminated the Appellant's services payment sending a Notice of Termination the same day as a contact telephone call. The telephone call was with a contact worker and lasted less than 5 minutes according to the worker's testimony. Furthermore, according to the worker's testimony, she had no prior dealings with the beneficiary. The uncontested evidence of record establishes the [redacted] year old Medicaid beneficiary suffers dementia and has been receiving home help assistance for a number of years. She receives assistance with activities of daily living as well as

instrumental activities of daily living that include transferring, bathing, dressing, medication assistance, meal preparation, housework, shopping and laundry. She had been receiving assistance 7 days a week for many tasks.

A review of the evidence in the record establishes that despite the report that the Appellant was incontinent and required assistance with toileting, and the worker's notations to that effect, the Department never changed the Appellant's functional rank for toileting, nor did it authorize payment for this task. Although payment approval notices were sent, there is no evidence either the Appellant or her provider were specifically informed which tasks payment had been authorized for. Because the Appellant and her provider lacked this specific information, neither could articulate a Department error to the worker. The provider was only able to articulate she believed she was not being paid enough. According to the evidence of record, she was right. The Department's policy supported changing the functional rank for toileting to at least 3 and then authorizing payment for that task, dating back to [redacted]. However, this oversight by the Department was not known to either the Appellant or her provider. When the provider telephoned to request an increase in payment for assistance, the contact worker informed her no increase was needed. Again, the provider was unable to articulate there had been an error because she had not been specifically informed by the Department how the payment assistance was calculated. **More importantly, however,** there is no evidence the contact worker sought consent from the Appellant to discuss her case with her provider or make dispositive determinations about it prior to engaging in the conversation about it. There is no evidence of record the Appellant's daughter is her legal guardian. The Department cannot recognize the provider as an agent of the appellant without overt authority. There was none here at the time the worker and the provider discussed this case. As a result, the contact worker engaged in a conversation about the Appellant's case with her provider without legal authority to do so. It is only from this conversation that the issue of closure came up at all. Furthermore, it is clear from the evidence of record the provider articulated her "request" to close the case to the contact worker, after coming up against unwillingness by the Department to consider an increase in payment.

Because it is not clear from the record the Department sought or obtained the Appellant's consent to discuss her case with her daughter, this ALJ cannot find the conversation that followed can have the legal effect sought by the Department. There is no evidence the utterance from the Appellant "please close" was knowing or represents her true consent in a legal sense. It was not established the Appellant even knew who she had been put on the telephone with. Nor could consent be given after the conversation had already taken place. Furthermore, it is not appropriate to accept a verbal statement via telephone from someone suffering dementia as a legally binding statement of their intention or desire.

While this ALJ is mindful the Appellant's daughter herself is the one who put her on the telephone and that this ALJ sought her consent for hearing verbally over the telephone, at the time verbal consent was sought by this ALJ, it was not known the Appellant

suffered dementia. It was only after due consideration of the records and documents contained in the case file that this ALJ determined the consent had been provided. The consent established was in writing and the record review done while the parties waited on the telephone, prior to proceeding with hearing. The record review revealed the Appellant had indicated her consent to have her daughter act on her behalf when she signed the request for hearing form specifying she needed to have special arrangements and that her daughter would take care of it. This ALJ was able to ascertain consent had been provided in writing prior to proceeding with the hearing, after an attempt to obtain a verbal consent revealed the dementia suffered by the Appellant, thus adequate protection for the Appellant's legal rights had been established.

The Department vigorously defended its action, asserting the fact the Appellant came to the phone and said "please close" is sufficient grounds to terminate the case. When pressed by this ALJ about the circumstances and context, the Department Manager stated not all family members require payment to assist other members and further stated that many other people do not prefer to have to deal with the Department, thus end up closing their cases as well. She did not address the fact that the Appellant is suffering dementia or the fact that the statement may not have been truly voluntary or consensual in the legal sense due to the language barrier or dementia. She did not assert the Department had established legal authority to accept her statement as given. Legal considerations for obtaining consent, particularly about medical issues do not support a finding that consent for action can happen after the action, nor does Adult Services Policy support taking statements out of context in order to close medical benefit cases. Finally, presumptively the worker had already determined the Appellant's provider was unwilling to provide the services free of charge or she would not have authorized the payment. Policy regarding case planning requirements establish this is properly considered at case plan development.

While this ALJ recognizes the people who wish to avail themselves of benefits have a responsibility to abide by the processes which exist to administer them, the Department bears the responsibility to take knowing and voluntary requests for case closure. There is no legal support for the notion that a person suffering dementia can come to the telephone, even at the behest of her daughter, and authorize a conversation to take place after the fact. The Code of Federal Regulations (431.213(b)) lends support to the finding that a statement expressing a desire for case closure be knowing and voluntary by indicating it is a circumstance under which the advance notice requirement can be waived. It indicates where a clear, written statement is received, signed, clearly indicating he no longer wishes to receive services, advance notice is not required. The requirement this expression be signed and in writing and clear provides protection against impulsive verbal utterances and potential misinterpretation of verbal statements by either party. In this case, the consent to case closure would have been evidenced as truly knowing and voluntary if it had been made in writing and signed by the beneficiary. Here, it is not established the Appellant knew who she was talking to or what would be closed.

In this case, because the provider was not authorized to speak on behalf of the Appellant prior to the conversation, the conversation at issue cannot be given legal effect. This ALJ finds there is little evidence to support a determination that the Department had properly determined the Appellant authorized her daughter to act on her behalf to close the services case when it engaged in the discussion with the provider, denied her a new assessment and consideration of an increase in payment. Because the Department had not made this determination, the conversation itself was not authorized and cannot be given the legal effect desired by the Department in this case.

The Department's error in the case is legally substantive thus cannot be upheld by this ALJ.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department acted improperly to terminate the Home Help Services case of the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/7/2011

***** 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 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.