STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2011-51500 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 held [redacted]. The Appellant represented himself at hearing. He appeared via telephone from his home.

[redacted], Appeals and Review Officer, represented the Department of Community Health. [redacted], Adult Services Supervisor, appeared as a witness on behalf of the Department. [redacted], Adult Services Worker, was present and testified on behalf of the Department.

ISSUE

Did the Department properly reduce Home Help Services (HHS) 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 is a participant in the HHS program.

2. The Appellant suffers COPD, is oxygen dependent and receiving hospice care at time of hearing.

3. The Appellant's HHS case was due for redetermination in [redacted].

4. The Department's worker went to the Appellant's home [redacted], to perform a comprehensive assessment [redacted].

5. At assessment during the home call, the Department's worker asked the Appellant what tasks he allowed his provider to perform on his behalf.

6. The Appellant informed the Department at home call in [redacted], he toilets himself, has meals on wheels delivered and his home chore provider did housekeeping, laundry, shopping and bathing and meal preparation of 1 meal per day, specifically breakfast.

7. Following the assessment of [redacted] the Department sent the Appellant an Advance Negative Action Notice reducing the payment authorized for HHS from [redacted] to [redacted] per month.

8. The Department's Notice states the "reductions will reflect housework and bathing." This Notice was mailed on or about [redacted]

9. The reduction actually reflected a reduction in the meal preparation time authorized each month from 25.05 hours to 12.32 hours per month.

10. The functional rank assigned for meal preparation is 3. The narrative with respect to meal preparation dated for the [redacted] home call indicates the Appellant is "unable to do task because weak and tires easily."

11. Additional narrative notes in the evidentiary record state the Appellant is getting meals on wheels and his provider prepares one meal daily for him. Also, there is an indication the Appellant has a friend who works in a restaurant who brings him food.

12. The Appellant did not feel well at the time of the home visit. (narrative notes)

13. The Appellant requested a hearing, which was held [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.

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,
7-1-2009.

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.

The Adult Services Manual (ASM 363 7-1-09), 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 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 redetermination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency 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 for food and other necessities of daily living
- 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 interviews with the customer and provider, observation of the customer'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 for food and other necessities of daily living
- 6 hours/month for housework
- 7 hours/month for laundry
- 25 hours/month for meal preparation

These are maximums; as always, if the customer 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 customer 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 customer's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the customer to perform the tasks the customer 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 customer.
- 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 customer 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 customer.
- HHS may be authorized when the customer is receiving other home care services if the services are not duplicative (same service for same time period).

Adult Services Manual (ASM) 7-1-2009.

Department policy addresses the need for supervision, monitoring or guiding below:

Services Not Covered By Home Help Services

Do **not** authorize HHS 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 - Medical transportation policy and procedures are in Services Manual Item 211.
- Money management, e.g., power of attorney, representative payee;
- Medical services;

- Home delivered meals;
- Adult day care

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 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)

The Department implemented reductions following an in home visit with the Appellant. The Appellant did have the time authorized for meal preparation assistance cut in half following the [redacted] home call. The Department witness asserted she was informed by the Appellant he receives meals on wheels, thus cut the time. Her notes indicate his provider prepares 1 meal a day and he has a friend bring meals from a restaurant.

The Appellant contested the veracity of the Department's witness in his written letter. He asserted she is inaccurate about meal preparation because he "quit" meals on wheels in [redacted] because the meals are too high in carbohydrates for him. He cites 2 additional inaccuracies. He further asserted he has called his worker 10 times and she never answers the telephone. The Appellant further asserts the Department's worker informed his provider she has 15 minutes a week to complete shopping. He said he does not know what he will do if his provider cannot be paid to cook for him. He also asserted he never told the worker he was getting a meal every day from his friend who works in a restaurant. He said that has rarely happened, maybe 2 times in all.

The Department witness asserted the Appellant has been asked for his contact information for the meals on wheels program to confirm he no longer participates with them and had yet to provide it.

At hearing this ALJ read all the evidence submitted by the Department and from the Appellant. It was noted the Appellant's health is not improving. He is receiving hospice care. There is uncontested evidence he is weak and tires easily. At hearing it was revealed the Appellant uses a bedside commode for toileting. The worker was asked if the Appellant is capable of emptying the commode without assistance. She said no. She was asked if she had obtained information about the Appellant's toileting process at the assessment completed in [redacted]. She said she had not. She never asked him about it. She did indicate she knew he used one.

This ALJ does not believe the Department's worker made up or fabricated information about how the Appellant is functioning when she made a home call in [redacted]. There is evidence however, that she failed to conduct a complete comprehensive assessment. Specifically, she knew he relies on a commode for toileting and that he cannot empty it without assistance. She never inquired about how this personal care task is completed. She did not determine if this is something his provider is doing, the hospice worker or another resource. This is important and should appear in the case record. Furthermore the worker did not change the Appellant's functional rank for meal preparation to reflect what she determined; which is that he is unable to do it because he tires easily and is weak. The rank of 3 is for those who can prepare simple meals and snacks and reheat food. It no longer appears appropriate where the narrative notes indicate he cannot do it and the reasons he cannot. Moreover, the narrative notes indicate the Appellant is ranked 3 for laundry, despite notes that indicate he cannot do it. The notes also indicate the Appellant is unable to shop for food or medication or do housework and bathing. His rank for shopping is 4, bathing 3 and housework is 4. These ranks are not consistent with narrative notes indicating inability to perform the tasks. Furthermore, there is uncontested evidence the Appellant has not left his home in at least 7 months. This does not entitle him to the maximum authorization for the tasks; however, the Appellant is actively contesting the claims of the Department witness. Therefore, this ALJ is tasked with determining witness credibility in this case. Because the Department seeks to use the evidence contained in the case record, in conjunction with testimony from the Department witness in order to refute the claims from the Appellant at hearing the completeness and accuracy of the case record are areas of consideration for this ALJ. Because the functional ranks are not reflective of the caseworker's own notes, the written record cannot be viewed as entirely reliable in this case.

As stated above, this ALJ does not believe the caseworker fabricated the material fact that the Appellant was receiving meals on wheels at the time of assessment in [redacted] The Appellant's claim is that he "quit" in [redacted], thus there is no actual conflicting information about that. While this ALJ is very sympathetic to the Appellant's situation, it is not appropriate to allocate the monthly maximum assistance for meal preparation

where the Appellant is receiving regular assistance from another resource. At the time of assessment, the information the Department acted on was accurate and good reason to reduce time for meal preparation. Bathing was reduced from 8 hours per month to 3 hours, 26 minutes per month. The uncontested evidence is that the Appellant receives a sponge bath 1-2 times per week. This amount of time is probably adequate to accomplish the task as described by the Appellant.

This ALJ does not find the case record for the tasks that were unchanged and not discussed at the home call could be found reliable at this time. The functional ranks are not reflective of the worker's notes and there is no evidence of record the worker made any changes to the case record where the functional rank is to be recorded, or the time and task other than those which were reduced. It is not known or established this worker made a determination about each task and compared it to the records in existence. What was evidenced is that she made a determination that bathing and meal preparation should be reduced and that is what she did. This is inadequate to establish she performed an adequate comprehensive assessment in this case.

This ALJ concurs with the determination of the Department's Adult Services Worker regarding the Appellant's need for meal preparation and bathing. The Department must, however, follow established procedures when completing reviews. The failure to consider the Appellant's toileting needs is an error and good evidence of an assessment that was incomplete.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly reduced the Appellant's HHS payment. However, it failed to complete an adequate comprehensive assessment in [redacted].

IT IS THEREFORE ORDERED that:

> The Department's decision is AFFIRMED in part and REVERSED in part. The Department is hereby ordered to complete a new comprehensive assessment for this Appellant.

_____

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

[redacted]
Docket No. 2011-51500 HHS
Decision and Order

cc: [redacted]

Date Mailed: 12/15/2011

***** 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.