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

[redacted],

Docket No. 2011-52664 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 was present and represented himself at hearing. His chore provider was present, [redacted].

[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's physician has reported the Appellant had rotator arm surgery years ago.

3. The Appellant self reports back pain, stomach infection and dental problems.

4. The Appellant's HHS case was due for redetermination in [redacted]. The case redetermination did not take place in [redacted].

5. The Appellant's provider stopped receiving payments in [redacted].

6. The Appellant went to his DHS office to inquire about lack of provider payments in [redacted]. He was seen in a face to face contact with the Supervisor at that time.

7. The Supervisor directly observed the Appellant ambulate without an assistive device during the face to face contact in the office. She thereafter reduced his HHS payment authorization by removing assistance for mobility and grooming.

8. The Appellant receives payment assistance for the tasks of housework, laundry, shopping and meal preparation. He has a functional rank of 3 for each of these activities.

9. The Department of Human Services authorized payments for the months of [redacted] and [redacted] at a reduced amount.

10. The HHS payment authorized for [redacted] and [redacted] was [redacted].

11. The HHS payment authorized for [redacted] was [redacted].

12. The Appellant was provided a Notice of payment reduction that was printed [redacted]

13. The Appellant requested a hearing [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 office visit by the Appellant, who was seeking explanation for the failure of the Department to pay his provider. There is no evidence a Notice of reduction, termination or suspension was ever sent prior to [redacted], despite the fact the Department stopped sending payments effective [redacted]. The explanation provided was that the redetermination was late, thus payments were not sent out. The Department is free to establish any redetermination requirements it sees fit, as well as determine the appropriate length of time between case redeterminations. However, the Department is not at liberty to suspend, reduce or terminate payments without the legally required 10 day Advance Negative Action Notice being sent first. The payments authorized under the HHS program are not certified for a one year period and subject to expiration in the same manner as food stamp authorizations. There is a requirement that Notice be sent. Thus, the suspension of the payments without Advance Notice was improper and must be corrected.

The redetermination of the case was addressed at the office visit of [redacted] and Notice of reductions thereafter sent to the Appellant. The Supervisor testified she completed the comprehensive assessment when the Appellant appeared at the office. She directly observed him walk unassisted, thus removed mobility as an authorized task. She determined the Appellant can cut his own nails and shave so she removed

grooming as a paid task. She assigned functional ranks of 3 for his Instrumental Activities of Daily Living (housework, shopping, laundry and meal preparation) and authorized payment accordingly.

The Appellant contested the reduction in payments by testifying he needs help carrying heavy items from the grocery store. When asked to provide an example of something too heavy, he stated watermelons and bags weighing over 5 or 10 lbs. He was asked if he could fold clean laundry and said no because bending is painful. He agreed he is able to open the refrigerator door with his hands. He has a driver's license and drives a car. He opens the car door unassisted. He testified he needs someone to watch him bath to make sure he does not fall. He said he can get things from the refrigerator and put them in the microwave.

In this case the Appellant contested the reductions implemented by the Supervisor who saw him in the office when he went to inquire about why his provider was not being paid. While the reductions can be supported by the direct observations of the Supervisor who made them during an in office contact, the process by which the reductions were implemented cannot be sustained. The Appellant contested the reductions prior to what should have been the earliest effective date following a determination that his functional status had improved. Thus, the reductions should not have gone into place pending the final decision issued by this ALJ. In this case, like others that have preceded it from the same county office, they were implemented retroactively. The uncontested evidence of record establishes the Notice was printed [redacted]. It could not have been made effective prior to [redacted], according to the Code of Federal Regulations and State Law. The request for hearing was received [redacted], prior to the expiration of what should have been the Advance Negative Action period during which actions are stayed. While in this case continuing the payment at previous levels for the time period between [redacted], [redacted], and the date this Decision and Order is received would have resulted in an over-payment, the Department errors are being addressed in this Decision and Order, thus this ALJ did not believe overlooking this error to be prudent. Although an overpayment could have resulted if the previous payment been received between [redacted], and the date of this Order, the payments for [redacted] and the first half of [redacted], would not constitute an overpayment because no Advance Negative Action Notice was sent until [redacted]. It is not possible for an overpayment to occur prior to the sending of the Notice because the Department determination remains in place until the sending of a Notice. In short, the payments for [redacted] of [redacted] should have remained at the levels prior to the effective date of a proper Advance Negative Action Notice. The payment for [redacted] up until [redacted], was precluded by law from being reduced. The reduced rate could become effective no sooner than [redacted], thus the Department errors concerning payments for [redacted] and [redacted] must be remedied.

This ALJ concurs with the determination of the Department's Adult Services Worker regarding the Appellant's need for Home Help Services assistance. The worker testified

in a credible manner about what she saw and what she determined was necessary to assist the Appellant. The Department must, however, follow established legal procedures when implementing reductions and as concerns redeterminations. The failure to send provider payments because the Department has failed to complete a case redetermination is not supported by law or policy. Stopping the provider payments because the redetermination is not done is in effect a suspension of payments without Advance Notice. This is clearly prohibited.

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 follow proper procedure in implementing the reductions and continuing payments prior to sending an Advance Negative Action Notice.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED in part and REVERSED in part. The Department is hereby ordered to issue corrective payments for the months of [redacted] and for [redacted] up to at least [redacted]

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

cc: [redacted]

Date Mailed: 11/23/2011

***** 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.