STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2011-8101 HHS
Case No. 89113125

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, [redacted] was present for the hearing. Her [redacted], [redacted] represented the Appellant and served as her translator. The Appellant's [redacted], appeared as the Appellant's witness. [redacted], represented the Department. [redacted] (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 on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary.

2. The Appellant is [redacted], who has been diagnosed with the following conditions: hypertension, diabetes, arthritis, and diabetic retinopathy. (Exhibit 1, pages 6 and 10)

3. On [redacted], the worker conducted an annual assessment to determine the Appellant's continuing need for HHS. (Exhibit 1, page 4)

4. Based on the information she obtained at the assessment, as well as the DHS 54-A medical needs form, the worker issued an Advance Negative Action Notice, informing the Appellant that her HHS payments were being

reduced to $[redacted] per month, effective [redacted]. Specifically, the following tasks were eliminated from the Appellant's chore grant: bathing, grooming, dressing, mobility, and medication. (Exhibit 1, page 3)

5. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's Request for Hearing. (Exhibit 1, page 2).

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.

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 addresses the worker's responsibilities with regard to assessments as follows:

> **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).

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.

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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.

Adult Services Manual (ASM 363) 9-1-2008, pages 2-7 of 24

The worker testified that she conducted an assessment on [redacted], and as a result of that assessment, she eliminated the hours authorized for the following tasks: bathing, grooming, dressing, mobility, and medication.

The worker explained that these tasks were eliminated from the Appellant's chore grant because, at the assessment, the Appellant's [redacted] stated that he was not assisting the Appellant with them. In addition, she explained that the most recent DHS-54A medical needs form from the Appellant's physician, which is dated [redacted] did not certify a need for assistance with any of the eliminated tasks.

The Appellant's [redacted] disagrees with the reductions. He stated that he does everything for the Appellant—he does whatever the Appellant asks him to do. He stated that he helps the Appellant in and out of the tub. He also stated that he helps the Appellant dress sometimes. He stated that he helps her put on her outer clothes, such as her shoes and her coat. However, he could not explain what type of clothing that the Appellant wears or how he assists her.

The Department's reductions in this case must be upheld. While the Appellant may in fact need assistance with these tasks, these needs were not articulated to the worker at the time of the assessment. Indeed, the Appellant's [redacted] conceded that he stated that he was not performing the tasks. However, given the language barrier in this case, as well as the inconsistencies between the information provided at the assessment and the testimony provided at the hearing, it appears that a new assessment is needed.

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 payments based on the information it had at the time it made its decision. However, a new assessment should be conducted to determine the Appellant's actual assistance needs.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED. However, the Department is ordered to conduct a new assessment to determine the Appellant's actual need for assistance.

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

cc: [redacted]

Date Mailed: 2/17/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules March 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 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.