STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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]

Appellant
_____/

Docket No. 2011-9066 HHS
Case No. 56767371

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], the Appellant, appeared on her own behalf. [redacted], appeared as a witness for the Appellant. [redacted], represented the Department. [redacted], and [redacted], appeared as witnesses for the Department.

ISSUES

1. Did the Department properly reduce the Appellant's Home Help Services (HHS) payments?

2. Did the Department act on the Appellant's request for an increase in Home Help Services with reasonable promptness?

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 [redacted] Medicaid beneficiary.

2. The Appellant has been diagnosed with diverticulitis, colovesical fistula, and low blood pressure. (Exhibit 1, page 11)

3. On [redacted], an Adult Services Worker made a visit to the Appellant's home to conduct a Home Help Services assessment. It was noted that the Appellant was to have another surgery in [redacted] and would call if she needs additional chore services. (Exhibit 1, page 7)

4. As a result of the information gathered from the assessment, the worker reduced the Appellant's HHS payment effective [redacted]. (Exhibit 1, page 8)

5. At the [redacted], the Appellant was discharged from the hospital. The Appellant and her chore provider made multiple calls to the Department requesting an increase in chore services. (Appellant and [redacted] Testimony)

6. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating that her Home Help Services payments would be reduced to $[redacted] effective [redacted]. (Exhibit 1, pages 4-6)

7. The Adult Services Worker who completed the [redacted] comprehensive assessment and made the [redacted] reduction has retired, and a new Adult Services Worker has been assigned to the Appellant's case. ([redacted] Testimony)

8. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's Request for Hearing. (Exhibit 1, page 3)

9. The Department has agreed to rescind the [redacted] reduction as there is not much information in the case file to support this action. (Adult Services Supervisor Testimony)

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

An Adult Services Worker (ASW) completed a home visit as part of a comprehensive assessment on [redacted]. This ASW has retired, but her home visit notes indicate that the Appellant was going to have an upcoming surgery and was to call in if she had additional chore needs. (Exhibit 1, page 7) Following this home visit, the ASW reduced the Appellant's HHS payments to $[redacted] per month, effective [redacted]. (Exhibit 1, page 8) The documentary evidence supports the Appellant's testimony that the ASW was going to reduce her HHS payment following the home visit to reflect the level of services she needed at that time, but was open to an increase after the scheduled surgery.

While the Department does not have any record of the Appellant's and chore provider's calls to the ASW in late [redacted] requesting an HHS increase, both the Appellant and chore provider gave credible testimony that multiple phone calls were made and messages were left when the voicemail box was not full. However, a call in post surgery would not be sufficient to implement an increase in the Appellant's payment under Department policy. A comprehensive assessment would be needed to determine how much of an increase, if any was appropriate.

The Department did not take any action on the Appellant's request for an HHS increase. However, the retired ASW did make another reduction to the Appellant's HHS case effective [redacted]. (Exhibit 1, pages 4-6 and 8) The Department acknowledged that advance notice was not given for this reduction and further offered to

rescind this action as there was little information in the case record to support this action. ([redacted] Testimony) The Department offered to return the Appellant's HHS payments to the rate she was receiving effective [redacted], [redacted]. However, the Appellant was unwilling to settle for $[redacted] per month due to her request in [redacted] for an increase due to additional care needs post surgery.

The case record does not support the [redacted] reduction to the Appellant's HHS payment. No new assessment was completed at that time, nor was any other evidence presented to justify the reduction. The [redacted] reduction shall be reversed, as the Department indicated they were willing to do.

The evidence also indicates that the Department failed to act upon the Appellant's request in [redacted] for an increase in her HHS services. The Appellant testified that she was discharged with an open wound, which is the reason she needs increased services. She further testified that this wound is still open and her care needs now are the same as they were upon discharge from the hospital. The [redacted] testified that the Appellant's case is also due for a re-assessment. Accordingly, as part of the re-assessment, the Department shall allow the Appellant time to provide documentation from her doctors of her surgery, discharge date, the additional care needs performed by her chore provider since her discharge (wound care, etc.) and that these needs have remained the same since discharge. If the re-assessment results in a higher HHS payment, and the verification is received from the Appellant's doctor, the higher payment amount should be made retroactive when the Appellant's doctor verified the need for increased services from the chore provider.

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 in [redacted] and failed to act upon a [redacted] request for an increase in services.

IT IS THEREFORE ORDERED THAT:

The Department's reduction to the Appellant's HHS payment effective [redacted] is REVERSED. The Department shall complete a new comprehensive assessment to determine the Appellant's HHS needs. The Department shall allow the Appellant the opportunity to provide verification from her doctor of:

- The date of her surgery and discharge from the hospital
- What additional care needs are performed by the chore provider since the discharge (wound care, etc.) and
- Whether these additional care needs have remained the same since the Appellant's discharge

If the re-assessment results in an increase to the HHS payment, and the verification is received from the Appellant's doctor, the higher payment amount should be made retroactive to when the Appellant's doctor verified the need for increased services from the chore provider. Otherwise, the Appellant's HHS payment shall be returned to $[redacted] per month effective [redacted], until advance notice is given of any reduction.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/4/2011

***** 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.