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

Docket No. 2012-33704 HHS
Case No. [redacted]

[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]. [redacted] was represented by his legal guardian and sister, [redacted].

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

ISSUE

Did the Department properly terminate 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 Medicaid beneficiary.

2. The Appellant is cognitively impaired as well as seriously mentally ill. He is legally adjudicated an incapacitated person. His legal guardian is [redacted], his sister.

3. The Appellant is unable to count. (case documentation in exhibit A)

4. The Appellant has multiple serious health issues including diabetes (insulin is injected daily), high blood pressure, chronic pancreatitis, copd

and schizophrenia. He receives in home skilled medical care at time of hearing.

5. The Appellant has been receiving Adult Home Help Services.

6. The Adult Services Worker (ASW) scheduled and completed a home call .

7. The home call was completed in with the Appellant's niece and the Appellant present.

8. Following the home call the ASW terminated the HHS assistance because she determined the Appellant was not receiving assistance with Activities of Daily Living as defined in policy.

9. The Appellant has been authorized to receive paid assistance with medication administration, housework, shopping, laundry and meal preparation through the Home Help Services program.

10. The Appellant has received unpaid assistance with bathing. (Testimony of the Appellant's legal guardian at hearing)

11. The Appellant still requires assistance with bathing, medication administration, shopping, housework, laundry and meal preparation in order to reside in the community safely.

12. Following the home call the ASW thereafter prepared an Advance Negative Action Notice informing the Appellant his HHS services payment assistance would be terminated effective due to the lack of need for "personal hands on care".

13. The Appellant appealed the determination on .

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:

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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).

Adult Services Manual (ASM) 9-1-2008

The Department issued an Interim Policy Bulletin effective October 1, 2011. It states in pertinent part:

Home Help Eligibility Criteria

> To qualify for home help services, an individual must require assistance with at least one activity of daily living (ADL) assessed at a level 3 or greater. The change in policy must be applied to any new cases opened on or after October 1, 2011, and to all ongoing cases as of October 1, 2011.
>
> Comprehensive Assessment Required Before Closure
>
> Clients currently receiving home help services must be assessed at the next face to face contact in the client's home to determine continued eligibility. If the adult services specialist has a face to face contact in the client's home prior to the next scheduled review/redetermination, an assessment of need must take place at that time.
>
> Example: a face to face review was completed in August 2011; the next scheduled review will be in February 2012. The specialist meets with the client in his/her home for a provider interview in December 2011. Previous assessments indicate the client only needing assistance with instrumental activities of daily living (IADL). A new comprehensive assessment must be completed on this client.
>
> If the assessment determines a need for an ADL at level 3 or greater but these services are not paid for by the department, or the client refuses to receive assistance, the client would continue to be eligible to receive IADL services.
>
> If the client is receiving only IADLs and does not require assistance with at least one ADL, the client no longer meets eligibility for home help services and the case must close after negative action notice is provided.

DHS Interim Policy Bulletin 10/1/11

The interim policy was in effect at the time of the assessment in December of 2011. The newly published policy was published January 1, 2012 and was in effect when the Notice was printed. They are both included in the Decision and Order for reference of the parties.

The material issue is whether the Appellant is able to perform his own Activities of Daily Living without physical assistance. This is material to the proper disposition of the case because if he is not in need of physical assistance, he no longer qualifies for assistance with the Instrumental Activities of Daily Living he is dependent upon in order to live in the community without seriously jeopardizing his own health. He is legally incapacitated. His sister is his guardian and provided uncontested, credible testimony concerning his abilities and needs. He has a host of serious medical conditions. He has medication he must take in order to stay out of the hospital, including insulin injections and psychotropic medication. He has cognitive limitations severe enough to prevent him from being able to count so he is not able to manage his own medications without assistance. His niece gives him insulin injections daily. He cannot prepare appropriate meals given his limitations. His guardian presented credible evidence that much must be done on his behalf. The guardian did equivocate about his need for physical assistance with Activities of Daily Living. She stated that maybe he did not need hands on help bathing but someone needed to get him in and out of the tub. She also stated someone has to turn the faucets for him. Her hearing request states clearly that he will just sit in the bathtub and do nothing if not assisted. At hearing she asked if eligibility is determined based upon his ability to get in and out of a bathtub. She clearly did not know much about the program's scope of services. She did not describe an assessment process that included being asked how Activities of Daily Living are completed.

The Department's witness was asked to describe or explain how she evaluated the Appellant's need for assistance with an Activity of Daily Living or personal care. She did not appear to understand the question asked of her so it was repeated. She then asked if the Department representative wanted her to read her narrative notes into the record. When told to do so, she then read her narrative into the record. Her narrative contained no evidence she assessed the Appellant's ability to perform his own personal care, or Activities of Daily Living. There is no documentation the ASW asked about any of the activities that comprise personal care, mobility or transferring. When specifically asked whether she had assessed each item individually by going over them one by one she said she had no recollection about that. Her narrative notes were read into the record in place of testimony concerning how she determined the Appellant is not receiving physical assistance with Activities of Daily Living. The narrative notes describe an assessment of the Instrumental Activities of Daily Living. They do not address the Activities of Daily Living. The narrative notes indicate the ASW asked the Appellant's niece, who is his enrolled provider, what she does for him. The Appellant's niece listed the Instrumental Activities of Daily Living and specified how often she does them. The worker asked the Appellant about "chore services" and he told her he is not around so he does not know what is done on his behalf.

This ALJ has considered all the evidence of record. There was no evidence at hearing that the Appellant's needs had been fully assessed, therefore the record of evidence is inadequate to support a termination of benefits in this case. The assessment completed cannot support a service termination. It is not known by the Appellant's legal guardian

what services are available and how eligibility is determined. The worker does not recall if she specifically assessed Activities of Daily Living, which is the very basis of eligibility due to the policy change. Despite not knowing if she did assess for them specifically, despite having no recollection about it and not having any narrative notes about Activities of Daily Living, the ASW sent a termination notice. This is not supported by policy.

The evidence of record, including the testimony from the ASW, the Appellant's guardian and the case documentation persuade this ALJ the Appellant's guardian was not asked sufficient questions about the Appellant's Activities of Daily Living in order to provide adequate information about the Appellant's needs at the time of the assessment. Here, the Appellant is legally incapacitated so his guardian speaks for him. While it may be true the Appellant's guardian did not fully describe his needs at the assessment, there is no evidence she was asked to fully describe his needs or how they are met. While it is true the ASW cannot read minds, it is her responsibility to perform an adequate assessment and develop a service plan. It may the case here that the Appellant is fully capable of performing his own ADLs and elects not to unless prompted. However, there is evidence he is cognitively impaired. He may not have the intellectual capacity to regulate the water temperature to a safe level and could scald himself if he tries to bath without physical assistance of water temperature regulation. This is but one aspect of what needs to be determined.

This ALJ is mindful of the over burdened Adult Services workers in the Department of Human Services, however, a termination of benefits for such a medically needy person requires adequate evidence of a truly comprehensive assessment. The Department seeks to support the termination of benefits based upon evidence that help was not asked for. This is an inadequate basis to support a termination where there is no evidence the appropriate questions were ever asked. Given the description of his functional status at hearing, this ALJ finds another assessment must be completed which includes a specific determination of each and every Activity of Daily Living, how it is performed and by whom.

The new policy enacted by the Department of Human Services does not provide HHS payment assistance for those with a medical need for assistance with Instrumental Activities of Daily Living, including medication administration, unless a worker determines there is also a need for physical assistance with an Activity of Daily Living. The eligibility requirements are more stringent than before. The determination that they are no longer being met must be supported by a better record of assessment than is present in this case.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department has not completed an adequate assessment to support its termination of the Appellant's benefits.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

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Jennifer Isiogu
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc:

Date Mailed: 10/15/2012

***** 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.