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

[redacted],

Docket No. 2012-3451 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. She was represented by her daughter, [redacted].

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

ISSUE

Did the Department properly authorize 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. Department records indicate she has dementia, bi-polar disorder and Parkinson's disease. Department records further indicate she has cataracts.

3. The Appellant receives payment assistance for Medication assistance, housework, shopping and laundry through the Home Help Services program.

4. The Appellant received payment assistance for the tasks of bathing, grooming and meal preparation until a reduction was made in [redacted]. The Notice of reduction was printed [redacted], and effective [redacted].

5. The worker's elimination of payment assistance for meal preparation, grooming and dressing was based upon the verbal statement from the Appellant who told her she had braided her own hair and washes herself.

6. A case review was completed in [redacted]. It was noted the Appellant's daughter/provider was very rude, angry and dissatisfied with the reductions taken in [redacted]. The notes further indicate the Appellant understood what was being discussed and why.

7. Additional notes from the [redacted] review state the Appellant's daughter "is claiming that she washes her mother's hair and braids it, she clips her toenails, she does the majority of the cleaning, she orders and picks up her mother's prescription and she cooks the main meal-dinner (in the crock pot)." No Notice was mailed following the [redacted] case review. The payment authorization remained unchanged.

8. The Appellant's daughter requested to be apprised of future home calls in advance so she could be present at the assessment. She was sent a Notice improperly indicating she must provide a copy of guardianship documentation in order to participate in an assessment, "per policy."

9. The Department worker made a collateral contact with the Appellant's doctor in [redacted] and was informed the Appellant requires "assistance with all care…dressing." It is noted "they do have a POA."

10. The Department's worker described seeing the Appellant standing at the stove with a pot on it and another time at the sink during the home call. She described what she saw as preparing a meal and cleaning up. The worker further testified she had no memory of a discussion about nail care performed on behalf of the Appellant by her daughter. (testimony of worker at hearing)

11. The Department sent a DHS 2010-B on [redacted]

12. The Appellant requested a hearing after not receiving a restoration of benefits, [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,
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.

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

SERVICE PLAN A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment. The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy Service planning is person-centered and strength-based. Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service. **Participants in the plan should involve not only the client, but also family, significant others, and the caregiver, if applicable. Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:**

- **Strengthening families and individuals.**
- **The role of family in case planning.**
- **Coordinating with all relevant community-based services, and**

- **Promoting client independence and self-sufficiency.**

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment. (Emphasis added by ALJ)

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)
9-1-2008.

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

Adult Services Manual (ASM)
9-1-2008

In this case the Appellant wanted payment assistance for the tasks of meal preparation, grooming, and bathing restored. She was denied, thus sought the hearing. The worker had made the reductions initially in [redacted] and reviewed the case in [redacted]. The payments were not restored to their original level as a result of the review. Additional information was obtained via collateral contact and the benefits were not restored. Although no Notice was sent, the failure to restore the payments upon the request and submission of additional evidence is in fact a denial by the Department. Additionally, the Appellant could assert a hearing right for lack of action despite a request for additional services.

A review of the documentation submitted in support of the Department's actions for this hearing reveal the initial cuts were made with only 2 days of advance notice. The Notice was printed [redacted], and effective [redacted]. Despite the

illegal action taken by the Department in effectuating the reductions without actual Advance Notice of them, this ALJ cannot order a remedy for this because the appeal period for those reductions has run. It is instructive to this ALJ as evidence of the Department's implementation of procedure and disregard for Policy, Federal and State law.

Further review of the documentation submitted in support of the Department's action for this case show the Department's last written contact with the Appellant is to require a copy of guardianship documents. It was explicitly stated to the Appellant that a copy of the papers were "required per policy" in order for the Appellant's daughter to participate in an assessment. This is not true. No policy citation is provided. Policy stated above instructs the workers to include the family members in service planning and be inclusive. Not only does the policy not require the provision of guardianship papers for the purpose cited by the worker, it instructs the workers to be inclusive of family members without mention of only including legally appointed guardians. The worker's statement to the Appellant is not only not supported by policy, it is not "required per policy" and it is contradicted by policy. This ALJ finds this instructive regarding the Department's interpretation of its own policy in this case.

At hearing, the Department sought to establish the failure to restore the benefits requested was supported by the assessment completed by the worker. The worker had full opportunity to testify and submit documentation to support her determinations. She stated she did not recall a conversation about nail care. This ALJ read notes from a [redacted] review indicating the Appellant's daughter reportedly cared for her mother's feet, including nail care.

The Appellant's daughter stated at hearing that she provides nail care to her mother's feet, washes and braids her hair as well. She said if the worker did see her mother at the stove it is because she may have been re-heating something she already prepared. She could also cook an egg. She further testified the worker comes without notice to home calls and has also stated she would come at 2:30 and arrived at 3:15. She further testified her mother is mentally ill, has dementia and she allows her to do as much as she can for herself.

This ALJ finds the worker's assessment is not supported by the Department policy and sufficient evidence of functional ability. The verbal reports from the Appellant should be corroborated by collateral contacts, direct observations and family members in order to be found reliable due to her dementia. The observation of the Appellant standing at the stove with a pot on it is insufficient to support the total elimination of meal preparation assistance. The report from her daughter/provider is that she makes the main meal of the day and that her mother is capable of reheating food already prepared or cooking something simple such as an egg. This is consistent with needing some limited assistance with meal preparation and not inconsistent with documented past reports to the worker. At hearing when this ALJ asked the worker to more fully describe what she saw the Appellant allegedly cooking, she was unable to say. While it is obvious to most, it bears stating in this case, there is a big difference between having the ability to heat

up a can of soup or previously prepared dish and being entirely responsible for all meal preparation without any physical assistance.

The worker's determinations about functional ability also must be congruent, in other words, make sense in relationship to each other. Eliminating meal preparation altogether is incongruous with a functional rank of 5 for medication assistance. There is very limited medication listed in evidence. If the Appellant is unable to take the small quantity of medicine without full assistance and has a diagnosis including dementia it is quite possible her verbal reports about what she does for herself should be viewed with skepticism.

This ALJ cannot find the assessment completed in apparent reliance upon the verbal statements from the Appellant who suffers dementia sufficiently reliable to support the Department's position in this case. Case documentation shows the worker had a collateral contact from the doctor's office corroborate the assistance approved previously for this Appellant was necessary. While it is clear the worker views the reports from the Appellant's daughter as lacking credibility, the information available from other sources is not given adequate consideration. There is documentation from the doctor of dementia and mental illness, in combination with physical frailty. There was no evidence of record explaining why the worker did not consider these factors when determining the appropriate functional rank. Additionally, the collateral contact directly to the doctor's office resulted in an opinion about the Appellant's functional capacity that was apparently disregarded. While policy does explicitly state the worker determines the functional rank, not the doctor, the worker must be able to support how the rank was determined. Her determination was contested by the Appellant's daughter. This is allowed at hearings and the proper subject matter of a hearing. In this case the worker decided to rely on verbal statements made by a woman suffering dementia rather than the statements from the doctor's office and caretaker/daughter. Yet, the worker kept the functional rank for medication assistance at 5. Why can't the Appellant take her own medicine? There is an implicit acknowledgment of the need for full assistance due to her cognitive limitations, but disregard of the same cognitive limitations about her verbal statements. The incongruity of these two determinations renders the assessment unreliable in this instance. Perhaps if the Department could provide credible, substantial evidence supporting the determination that the same person who is incapable of administering her own psychotropic medication to herself can provide more reliable reports about her functional abilities than her doctor or her daughter, this ALJ could have found the assessment more reliable. Here, however, the totality of evidence in the record is not supportive of a finding that the worker's actions are supported by Department policy, including the determinations of the Appellant's functional ability. There is scant credible, descriptive evidence of the functional abilities of this Appellant in the case documentation. There is a disregard for the nail care provided, despite a note in the [redacted] narrative. The lack of regard for the Advance Notice requirement of policy, state and federal law and the false representation to the Appellant's own daughter that she must produce guardianship documents in order to even participate in an assessment evidences the Department has not properly interpreted or applied policy 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 failed to complete an adequate comprehensive assessment at the last review. A new comprehensive assessment must be completed with an effective date of [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

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

cc: [redacted]

Date Mailed: 12/29/2011

***** 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.