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

Docket No. 2012-4584 HHS
Case No. [redacted]

[redacted]

Appellant
_____/

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], and completed on [redacted], Paralegal, [redacted], represented the Appellant. [redacted], the Appellant, appeared and testified. [redacted] caregiver, appeared as a witness for the Appellant. [redacted], Appeals Review Manager, represented the Department. [redacted], Adult Services Worker (ASW), appeared as a witness for the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services (HHS) authorization?

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. (Exhibit 2, page 4, Exhibit C)

2. The Appellant has a history of multiple medical impairments, including schizoaffective disorder, panic disorder, bipolar, Marfan syndrome, chronic pain syndrome, fibromyalgia, seizures, migraine headaches, and degenerative joint disease. (Exhibit 1, page 21; Exhibit 2, pages 4 and 7-9; Exhibit B; Exhibit C; and Exhibit H)

3. The Appellant had been receiving a total of 108 hours and 21 minutes of HHS per month for assistance with bathing, grooming, dressing, eating,

medication, housework, laundry, shopping, meal preparation, toileting, transferring and mobility with a monthly care cost of [redacted]. (Exhibit 2, page 5)

4. The Appellant has a spend down, or deductible, of [redacted] that must be met each month to be eligible for Medicaid. The Appellant has been using her HHS authorization to meet her monthly spend down. (Exhibit 1, page 16)

5. On [redacted] the Appellant's doctor completed a DHS-54A Medical Needs form listing the diagnosis code for schizoaffective disorder and certifying that the Appellant has a medical need for assistance with eating, toileting, bathing, grooming, dressing, transferring, mobility, taking medications, meal preparation, shopping, laundry, and housework. (Exhibit 2, pages 4 and 7-9)

6. On [redacted], a prior ASW completed a review of the Appellant's HHS case. (Exhibit 1, page 15)

7. On [redacted], ASW [redacted] made a visit to the Appellant's home to conduct a HHS assessment. No advance notice of the appointment was given, and the Appellant was not home that morning when the ASW knocked on her door. The ASW was able to complete the home visit with the Appellant that afternoon. (Testimony of ASW, Appellant and Caregiver, Exhibit 1, pages 9-15)

8. The ASW determined that the Appellant's ranking should be adjusted and the HHS hours should be reduced. The Appellant was ranked as a level 4 for medication, and shopping; a level 3 for bathing, grooming, dressing, mobility, housework, and meal preparation; a level 2 for toileting, eating, and laundry; and a level 1 for continence, and respiration. The HHS hours for eating, laundry, toileting, and transferring were eliminated. The HHS hours for grooming, housework, meal preparation, and mobility were reduced. (Exhibit 1, pages 17-20; Exhibit 2, page 5)

9. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating her HHS case would be terminated effective [redacted]. The termination was based on the ASW approval for 75 hours and 4 minutes ([redacted]) per month for her HHS case, which is less than her monthly spend down of [redacted] per month. (Exhibit 1, pages 5-7)

10. On [redacted], the Appellant's doctor completed a DHS-54A Medical Needs form listing diagnoses of chronic pain syndrome, fibromyalgia, seizures, schizoaffective disorder, migraine headaches, and degenerative joint disease. The physician certified that the Appellant has

a medical need for assistance with eating, toileting, bathing, grooming, dressing, transferring, mobility, taking medications, meal preparation, shopping, laundry, and housework. (Exhibit C)

11. On [redacted] the Appellant's Request for Hearing was received. (Exhibit 1, page 4)

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.

The Adult Services Manual (ASM) addresses eligibility for Home Help Services:

> **ELIGIBILITY FOR HOME HELP SERVICES**
>
> Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.
>
> **Medicaid/Medical Aid (MA)**
>
> Verify the client's Medicaid/Medical aid status.
>
> The client may be eligible for MA under one of the following:
> - All requirements for MA have been met, or
> - MA deductible obligation has been met.
>
> The client must have a scope of coverage of:
> - 1F or 2F, or
> - 1D or 1K (Freedom to work), or
> - 1T (Healthy Kids Expansion).
>
> Clients with eligibility status of 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple (sic) that daily rate by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and the ES.

Conditions of eligibility:

- The client meets all MA eligibility factors except income.
- An ILS services case is active on CIMS (program 9).
- The client is eligible for personal care services.
- The cost of personal care services is **more** than the MA excess income amount.
- The client agrees to pay the MA excess income amount to the home help provider.

Adult Services Manual (ASM) 363, 9-1-2008 pages 7-8 of 24.

Adult Services Manual (ASM 363, 9-1-08), also addresses the comprehensive assessment, functional assessment, time and task authorization, service plan development, necessity for services, and services not covered:

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. 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:

- 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.

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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 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-54-A.

- 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).

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Necessity For Service
The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client 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.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

> The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services.
>
> ***
>
> **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

The Appellant had been receiving a total of 108 hours and 21 minutes of HHS per month for assistance with bathing, grooming, dressing, eating, medication, housework, laundry, shopping, meal preparation, toileting, transferring and mobility with a monthly care cost of [redacted] (Exhibit 2, page 5) The Appellant had been using her HHS authorization to meet her monthly spend down of [redacted] per month. (Exhibit 1, page 16)

On [redacted], ASW [redacted], who was newly assigned to the Appellant's HHS case, made a visit to the Appellant's home to conduct a HHS assessment. No advance notice of the appointment was given, and the Appellant was not home that morning when the ASW knocked on her door. The ASW was able to complete the

home visit with the Appellant that afternoon. (Testimony of ASW, Appellant and Caregiver, Exhibit 1, pages 9-15) The Appellant raised issues regarding the ASW's conduct that morning when the Appellant was not home and during the afternoon when the assessment was completed. However, this ALJ can only address the action taken on the Appellant's case. Any issues regarding the ASW or the ASW's co-worker who was also present for the home visits, should be addressed with the ASW's supervisor. The Appellant should also contact her Medicaid eligibility worker to discuss utilizing medical expenses other than her HHS authorization to meet her monthly spend down.

While Department policy does not specify that advance notice of a home visit must be issued, showing up unannounced does not allow for a HHS recipient to be prepared and have relevant documentation available. In this case, the Appellant asserted that she did not have documentation ready that she would have had for assessments with the prior ASW, including medical verifications. For the [redacted], assessment, the ASW utilized a DHS-54A Medical Needs form from the prior review in [redacted], which only listed the diagnosis code for schizoaffective disorder. (Exhibit 2, pages 4 and 7-9) This ASW was new to the Appellant's case and would not have been familiar with the medical certifications the Department has received for the Appellant in prior years that were used in determining the prior HHS authorizations. (See Exhibit 1, page 21) Further, the Advance Negative Action Notice of the termination was issued less than a week after the home visit, precluding the Appellant's opportunity to provide medical verifications of her other diagnoses for this ASW. (Exhibit 1, pages 5-7) For these hearing proceedings, the Appellant submitted DHS-54A Medical Needs form completed by her doctor on [redacted], listing several additional current diagnoses: chronic pain syndrome, fibromyalgia, seizures, migraine headaches, and degenerative joint disease. The physician certified that the Appellant has a medical need for assistance with eating, toileting, bathing, grooming, dressing, transferring, mobility, taking medications, meal preparation, shopping, laundry, and housework. (Exhibit C) The Appellant was also able to provide documentation of her diagnosis of Marfan Syndrome. (Exhibit B) The Appellant provided credible testimony that she can have bad days with some these conditions, during which she is basically bed ridden.

The [redacted], Advance Negative Action Notice issued in the Appellant's case contains an error regarding the hours approved by the ASW. The notice states "Client approved for 75:04 HRS ([redacted]) per month HHS. (Exhibit 1, page 5) Clearly this is an error as an authorization of 75 hours and 4 minutes per month of HHS at a rate of $8.00 per hour would total more than [redacted]. This appears to be a computer error carried over from the Time and Task screen where the computer system did not take out hours from the eliminated activities in calculating the total hours of HHS per month. (Exhibit 1, page 17) Accordingly, this ALJ understands that it would be difficult to understand the Department's proposed termination based on the notice as written, indicating an approval for just over 75 hours of HHS. However, the ASW's determination was to reduce the Appellant's HHS authorization to a total monthly care cost of [redacted].

The ASW determined that the Appellant's rankings should be adjusted and the HHS hours should be reduced. The Appellant was ranked as a level 4 for medication, and shopping; a level 3 for bathing, grooming, dressing, mobility, housework, and meal preparation; a level 2 for toileting, eating, and laundry; and a level 1 for continence, and respiration. The HHS hours for eating, laundry, toileting, and transferring were eliminated. The HHS hours for grooming, housework, meal preparation, and mobility reduced. (Exhibit 1, pages 17-20; Exhibit 2, page 5) The Appellant disagrees with the reductions the ASW made to her HHS authorization.

The testimony indicates that there were miscommunications regarding the Appellant's functional abilities and needs during the [redacted], home visit. For example, the ASW's notes indicate she understood that the caregiver only goes to the Appellant's home 4-6 days per week. Therefore, she inferred that the Appellant is able to let the dogs in and out of the back door, put up a baby gate to confine the dogs to the kitchen, and care for herself and the dogs on the days her caregiver does not go to her home. (Exhibit 1, page 9) The Appellant and her caregiver credibly testified that the caregiver spends 4-6 hours each day at the Appellant's home, the Appellant does not adjust the baby gate, only one dog comes into the home at night, and the caregiver feeds and waters all dogs daily. This would impact the inferences the ASW made regarding the Appellant's functional abilities based on her belief that there are days the caregiver does not go to the Appellant's home. Based on the credible testimony of the Appellant and her caregiver, it appears that miscommunications occurred regarding many other areas of the assessment.

Additionally, some questionable determinations were made regarding the Appellant's functional abilities when the authorization is looked at as a whole. For example, the ASW eliminated HHS hours for laundry. The ASW's notes and testimony indicate she determined that the Appellant could pick up clothes, place them in a round laundry basket on the seat of her wheeled walker and push this to/from the washer dryer. However, the ASW's notes indicate the Appellant reported she can not bend past her knees without pain and HHS hours were authorized for bathing in part to assist with washing calves and feet, for grooming in part for cutting toenails, and for dressing in part for putting on socks. (Exhibit 1, pages 9-14 and 17-20) An ability to bend over to pick up clothes to do laundry independently is not consistent with the ASW's determinations regarding bathing, grooming, and dressing.

The evidence indicates that the [redacted], home visit did not result in a reliable assessment of the Appellant's functional abilities and needs for assistance. It does not appear that all of the Appellant's medial impairments were considered, several of which are likely to result in good and bad days with these chronic conditions. What the ASW may have observed on the day of the home visit may not necessarily be representative of the Appellant's abilities on bad days. It appears there were many misunderstandings about what was said during the home visit, and some of the ASW's determinations were inconsistent. The ASW's determination to reduce the Appellant's HHS authorization to a total monthly care cost of [redacted] can not be upheld. Accordingly, the termination based on a HHS authorization less than her spend down amount is reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly terminated the Appellant's HHS authorization.

IT IS THEREFORE ORDERED THAT:

The Department's decision is REVERSED. The Appellant's HHS authorization shall be reinstated at the previously authorized total of 108 hours and 21 minutes per month with a monthly care cost of [redacted].

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

cc: [redacted]

Date Mailed: 2/29/2012

***** 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.