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

[redacted],

Docket No. 2012-9428 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]. [redacted] represented herself.

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

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 who has been receiving adult Home Help Services.

2. The Appellant has been receiving payment assistance for bathing, an activity of daily living, as well as instrumental activities of daily living, through the HHS program. Specifically, she has received payment assistance for bathing, housework, laundry, meal preparation and shopping.

3. The Appellant resides alone. She is diagnosed with diabetes, neuropathy, hypertension, osteoarthritis, hiatal hernia and coronary artery disease. She is ambulatory with a cane.

4. The Department's worker made a home call to perform a comprehensive assessment and inform the Appellant of new Department policy.

5. The Department's worker completed the comprehensive assessment at the home call, determining the Appellant had no need for physical assistance with bathing. She thereafter terminated all home help assistance due to her determination about bathing.

6. The worker based her determination that the Appellant did not actually receive hands on assistance with bathing based upon what the Appellant told her at the assessment. The Appellant is reported to have informed the worker that the provider sits on the couch when she bathes.

7. The Department sent the Appellant an Advance Negative Action Notice [redacted], informing her of the termination of HHS benefits, effective [redacted].

8. The Appellant appealed the determination on [redacted].

9. The Department closed the Appellant's Home Help Services case despite its notice informing the Appellant if she requested a hearing prior to the effective date of the Advance Negative Action Notice the case would not close.

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).
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> *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*

In this case the evidence of record establishes the worker sent an Advance Negative Action Notice following a comprehensive assessment of the Appellant in her home. The date of the assessment is not known, however, was not raised by the Appellant, nor the Department. At the assessment, the worker inquired about the Appellant's assistance case and was informed the provider is sitting on the couch while the Appellant bathes. The worker thereafter determined the Appellant did not require hands on assistance with bathing. She reduced the functional assessment rank from 3 to 2, secured a shower grab bar for the Appellant and closed her case. She closed the case after reducing the functional rank for bathing, the only activity of daily living for which the Appellant had a rank of at least 3, citing new policy that requires a functional rank of 3 or higher for an activity of daily living in order to be eligible to get any home help assistance. The Appellant appealed the termination of her case and did so timely.

Despite the timely hearing request, the Department closed her case anyway. The Department disregarded the Federal, State and Policy requirement that the case remain open when a hearing is timely requested. There was no evidence presented indicating the Appellant requested the payments be suspended or the case closed pending hearing in order to avoid possible recoupment. Nor is there evidence the payments were suspended. The evidence is that the case was closed. There is no basis to make a finding the case closure was proper.

At hearing the Appellant stated she uses a cane and has a history of falls. She said she has a therapist come to her home 2 days a week in an effort to improve her functioning. She said she has pain even when dressing. She asserted she fell at the grocery store due to lightheadedness. She said she showers 3 days per week when she can get her daughter or neighbor to come over. She explained she has neuropathy.

This ALJ is without authority to alter the policy of the Department of Human Services. It vests authority to make a determination of need for services with their workers. The workers are to listen to input from the clients, as well as consider the medical evidence when making the determination. In this case the worker elected to place all weight in the words from the client and give no weight to her medical condition when determining her need for assistance with bathing. Mobility and transferring were not raised at hearing by the Appellant. This ALJ cannot reverse the Department's determinations if they are supported by policy.

The policy clearly requires the Appellant have a need for physical assistance with an activity of daily living in order to continue receiving assistance with instrumental activities of daily living. Here, the comprehensive assessment conducted was supported by the information collected by the worker during the assessment. Specifically, the Department considered only the words spoken by the Appellant about bathing. As a result of speaking these words, the worker determined no assistance was needed for bathing. This action is supported by policy, thus cannot be reversed by this ALJ. The Appellant is free to reapply for assistance at any time and is encouraged to do so. This ALJ cannot actually provide a remedy for the Appellant that addresses the fact that the Department did not adhere to the Federal and State laws, as well as Department policy regarding Advance Negative Action Notices. Despite the lack of legal grounds for closing the case, this ALJ will not order the Department to comply with the Federal Code of Regulations, State law and policy by re-opening the Appellant's case and paying her benefits, only to subject the Appellant to a recoupment action.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department has the support of policy in its termination of the Home Help Services benefits for the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 1/27/2012

***** 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.