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. 2009-10216 HHS
Case No. [REDACTED]
Load No. [REDACTED]

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]. [REDACTED] (Appellant) appeared and testified on her own behalf. [REDACTED], represented the Department. [REDACTED], appeared and testified as a witness for the Department.

ISSUE

Did the Department properly reduce Appellant's Home Help Services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [REDACTED] year-old Medicaid recipient who receives home help services.

2. At all times relevant to this matter, Appellant was receiving unearned income and had a monthly Medicaid deductible (formally spend-down amount) of [REDACTED].

3. Appellant was living with her brother and another individual who receives home help services at the time relevant to this matter. (Exhibit 1, p. 11)

4. Appellant is a right leg amputee who was diagnosed with diabetes, neuropathy of the left foot, cellulites, chronic wounds, edema, and depression; and she has a history of a heart attack. (Exhibit 1, p. 7)

5. Appellant had been receiving home help services for assistance with bathing, grooming, dressing, toileting, transferring, medication, housework, laundry, shopping for food/meds, range of motion exercises, and wound care. (Exhibit 1, p. 9)

6. On [redacted] the Adult Services Worker went to Appellant's home to reassess Appellant's eligibility for home help services.

7. After the home help services reassessment in [redacted], the Adult Services Worker determined that: assistance with toileting, bathing, and grooming must be removed because Appellant reported that she is able to do these things on her own; assistance with transferring must be reduced because Appellant needed less assistance with this activity, and she is able to transfer herself in her wheelchair and get in and out of bed; assistance with housework must be reduced because of Appellant's shared living arrangement; assistance with wound care and range of motion must be removed because Appellant reported that these activities were no longer being done by her provider; and Appellant needs assistance with meal preparation. (Exhibit 1, pp. 8-10)

8. Appellant's assistance with medication and transferring was given a ranking of 3, dressing was ranked at level 4; and housework, laundry, meal preparation, and shopping were given a ranking of 5 on the Independent Living Services Five-Point Functional Scale. (Exhibit 1, p. 8)

9. On [redacted], the Adult Services Worker sent the Appellant an Advance Negative Action Notice, informing her that her home help services payment would be reduced to [redacted]. (Exhibit 1, p. 13)

10. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the reduction of her home help services.

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.

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 re-determination.
- 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. Customers must require assistance with at least one qualifying ADL in order to qualify for HHS payments. A qualifying ADL (functionally assessed at Level 3 or greater) would include:

- An ADL functional need authorized by the worker

- An ADL accomplished by equipment or assistive technology and documented by the worker, or
- An ADL functional need performed by someone else, requiring no Medicaid reimbursement, or
- A request authorized as necessary through an exception made by the Department of Community Health, Central Office.

Once an ADL has been determined or exception request has been granted, the customer is then eligible for any ADL or IADL authorized home help service.

ASM 363; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES
ASB 2004-006 10-1-2004

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).

ASM 363; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES ASB 2004-006 10-1-2004

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;

ASM 363; pages 9 or 26; 10 of 26 and 15 of 26; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES ASB 2004-006 10-1-2004

RESPONSIBLE RELATIVE

A person's spouse.
A parent of an unmarried child under age 18

ASM 361; page 6; INDEPENDENT LIVING SERVICES PROGRAM OVERVIEW ASB 2004-006 10-1-2004

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) 10-1-2004

Medicaid Personal Care Option

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

Discuss this option with the customer and the ES.

Conditions of eligibility:

- The customer meets all MA eligibility factors except income. • An ILS services case is active on CIMS (program 9).
- The customer is eligible for personal care services.

- The cost of personal care services is **more** than the MA excess income amount.
- The customer agrees to pay the MA excess income amount to the home help provider.

Inform the ES of the amount of personal care services (HHS care cost) **and** the amount of personal care required but not approved for HHS payment, i.e., monthly payment does not meet total care needs.

If **all** the above conditions have been met, the customer has met MA spend-down requirements. The ES will send written notification of the MA effective date and the MA excess income amount.

Upon receipt of the ES notification, enter the customer's spend-down amount in **the Resources** tab of the **Basic Customer** module in **ASCAP**.

Note: Use the Services Approval Notice (FIA-1210) to notify the customer of HHS approval when MA eligibility is met through this option. The notice must inform the customer that the HHS payment will be affected by the spend-down amount, and that the customer is responsible for paying the provider the MA excess income amount (spend down) each month.

Do **not** close a case eligible for MA based on this policy option if the customer does not pay the provider. It has already been ensured that MA funds will not be used to pay the customer's spend-down liability. The payment for these expenses is the responsibility of the customer.

Notify the ES in writing of any changes in the customer's personal care needs. The ES will send written notification of any changes in the monthly MA excess income amount.

MA eligibility under this option **cannot** continue **if:**

- The customer no longer needs personal care; **or**
- The cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Program Eligibility Manual (PEM) 545, Exhibit III, regarding the Medicaid Personal Care Option.

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.

ASM 363; page; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES ASB 2004-006 10-1-2004

Home help services are paid for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive Home help services. The Department must verify the customer'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).

> Customers with Eligibility Status 07 and Scope of Coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA spend-down obligation.
>
> ***ASM 363; page 7; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES; ASB 2001-008 1-1-2008***

In this case, Appellant requested a hearing, protesting the reduction of her home help services. In [redacted], the Adult Services Worker completed a comprehensive home help services assessment of Appellant. During the reassessment, the Adult Services Worker determined that: assistance with toileting, bathing, and grooming must be removed because Appellant reported that she is able to do these things on her own; assistance with transferring must be reduced because Appellant needed less assistance with this activity, and she is able to transfer herself in her wheelchair and get in and out of bed; assistance with housework must be reduced because of Appellant's shared living arrangement; assistance with wound care and range of motion must be removed because Appellant reported that these activities were no longer being done by her provider; and Appellant needs assistance with meal preparation. Further, the Department can authorize home help services **only** for the benefit of the customer, **not** for others in the home. If others are living in the home, the department must prorate the IADLs, which include housework, laundry, meal preparation and shopping for food/meds by at least 1/2, or more if appropriate. Based on the evidence on the record, all of the IADLs were not prorated because Appellant was the only person receiving the benefit of getting assistance with the particular IADL.

The Department established that the Adult Services Worker conducted her home help services reassessment of Appellant in accordance with Department policy. The Adult Services Worker allocated the time and ranking for all of the ADLs and IADLs that Appellant needs assistance with based her reassessment of Appellant in [redacted]. The Department established that the Adult Services Worker followed policy and used the reasonable time schedule as a guide in determining the time that would be allocated for each task given a ranking of 3 or higher. There is no evidence to establish that Appellant had any special needs that required a deviation from the reasonable time schedule set forth in Department policy. The home help services policy states clearly that the Adult Services Worker is responsible for determining the necessity and level of need for home help services. Although the client's physician must certify that the client's need for services is related to an existing medical condition, the physician does not prescribe or authorize personal care services.

Appellant failed to provide the necessary evidence to refute the Department's home help services eligibility determination. Accordingly, the reduction of her home help services must be upheld.

Lastly, there was no dispute that at all times relevant to this matter, Appellant had a monthly MA spend-down amount of [redacted], which exceeds the new monthly home help

services payment that she was determined eligible to receive. According to Department policy, Appellant must be Medicaid eligible with a MA Scope of Coverage of 1F or 2F in order to be eligible for home help services. Clients are not eligible for Medicaid or Medicaid covered services such as home help services until they have met their MA spend-down amount.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly reduced Appellant's Home Help Services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

____
Marya Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 3/27/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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 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.