STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-14544 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]. The Appellant's daughter/chore provider represented him at hearing. [redacted], [redacted] for the Department of Community Health, represented the Department. [redacted], appeared as a witness.

ISSUE

Did the Department properly reduce Home Help Services 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 an [redacted]-year-old Medicaid recipient. He is married, resides with his wife, who is also a Medicaid beneficiary. She has a companion case.

2. The Appellant has rheumatoid arthritis, high blood pressure, diabetes, vertigo and chronic renal failure. He is ambulatory, using a cane for assistance.

3. The Appellant has been receiving Home Help Services (HHS) through the Department of Human Services (DHS).

4. The Appellant's HHS case was scheduled for an annual review and comprehensive assessment in [redacted].

5. The DHS Adult Services Worker conducted a comprehensive assessment at the Appellant's home on [redacted]. As a result of the assessment the worker increased payments for housework and laundry services. Reductions to bathing, laundry and meal preparation were implemented.

6. The Department notified the Appellant his HHS payments would be reduced from [redacted] to [redacted] per month in a notice mailed [redacted].

7. The Appellant requested a formal, administrative hearing [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.

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.

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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 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).

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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.

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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:

- 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.
>
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In this case the Appellant's daughter and wife assert the Appellant is older and more frail than when the case was first opened so it does not make sense that the services would be reduced as he ages. His daughter testified she does everything for each of her parents. She did testify he is able to feed himself and dress himself. She stated he requires help putting his socks on due to a fall. She asserts he is unable to assist doing laundry. Under questioning from this ALJ about what prevents him from helping to sort, fold or put away laundry, the response was repeatedly that he is old and it is hard work to do. No testimony was provided explaining what medical condition prevents the Appellant from folding an item of clothing. There was an assertion it could result in injury to her father. This is baseless as folding laundry (while seated) is more safe than walking in the opinion of this ALJ. This ALJ does not doubt the Appellant's daughter actually performs the services for her father and her mother, however, evidence that she does all of this is not evidence of his inability to do it for himself. The issue is whether he can do it, not whether he is actually doing it. This ALJ finds the Appellant's testimony fails to meet the burden of proof. In other words, the Appellant has not established with credible competent evidence the Department's determination was incorrect. Payment for some services were increased, reduced for others. This evidences the worker considered each task and the physical ability of the Appellant to participate or perform it for himself. Additionally, consideration had to be given to the extent each spouse can assist the other.

The time for meal preparation was reduced by the worker following the comprehensive assessment. The provider had indicated she makes a full dinner each night for the Appellant. The Appellant was given a rank of 3 and the time for meal preparation was pro-rated between himself and his wife, who has a companion case. There was no evidence to persuade this ALJ the Appellant is not capable of getting himself a bowl of cereal, making toast or a sandwich for himself. Assistance with dinner preparation is adequate given the evidence of record. Again, the fact his daughter elects to do everything for him does not evidence his inability to do some things for himself. The worker determined he has the physical ability to do some (simple) meal preparation for himself and ranked him accordingly. In this case, the evidence of record establishes the Appellant requires help with bathing, laundry and some help with meal preparation. That assistance is provided at the appropriate level.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department's actions are supported by Policy and credible evidence the assessment was proper.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/8/2009

***** 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.