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

,

Appellant
_________________________/

Docket No. 2009-14545 HHS
Case No.
Load No.

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 on . The Appellant's daughter/chore provider represented her at hearing. for the Department of Community Health, represented the Department. , 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 a -year-old Medicaid recipient. She is married and resides with her husband, who is also a Medicaid beneficiary. He has a companion case.

2. The Appellant has had bi-lateral breast cancer, high blood pressure, arthritis, diabetes, vertigo and is visually impaired in her left eye. She is ambulatory.

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 .

5. The DHS Adult Services Worker conducted a comprehensive assessment at the Appellant's home on . As a result of the assessment decreased payments for bathing, laundry, grooming, shopping and meal preparation were implemented.

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

7. The Appellant requested a formal, administrative hearing .

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.
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> 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 asserts 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 she ages. Her daughter testified she does everything for each of her parents. She did testify she is able to feed herself. It was determined at hearing the Appellant does require some assistance dressing and it was omitted from the payments approved following the assessment. The Department's worker agreed payment assistance for dressing should be added.

The Department's worker testified she went to the assessment and asked about changes in the Appellant's medical conditions and needs and was informed there were no changes needed. As a result of the assessment, case adjustments were made to reflect the need to prorate for certain tasks shared between the Appellant and her husband. Housework, laundry, shopping and meal preparation were assigned values according to the rank and then split or pro-rated between the two. She stated there is a maximum time allowed for laundry and she split the maximum time allowed per policy between the Appellant and her husband, who has a companion case. Additionally, time for meal preparation was divided between the Appellant and her husband, resulting in each being allocated 8 minutes per day meal preparation time. This is a total of 16 minutes per day for the couple, who was assessed a 3 for functional assessment. This was based upon a determination they were having dinner prepared for them and were capable of making light meals and snacks for themselves.

This ALJ took testimony from the Appellant's daughter, who is her chore provider. Her testimony established she performs a lot of housework, personal care and meal preparation for her parents. Her testimony did not establish her mother is physically unable to perform some meal preparation for herself, nor did it establish her mother is incapable of assisting in folding and putting away laundry. The issue is not what is actually done on behalf of the Appellant, rather, what she is capable of doing and not doing. She may only be authorized to receive assistance for certain tasks she is functionally incapable of doing without assistance. This ALJ is not persuaded by the testimony presented on behalf of the Appellant that the Department's determination of the Appellant's functional status was incorrect. The burden of proof is with the Appellant to establish the Department's determination was incorrect and must be reversed. In this case, the most credible and persuasive evidence of record establishes the Appellant requires help with dressing, bathing, laundry, housework and some help with meal preparation. That assistance is provided at the appropriate level. The worker agreed on the record the Appellant should receive assistance with dressing. The determinations made by and agreed to by the worker are found to be appropriate.

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.

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

cc:

Date Mailed: 5/11/2009

***** 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.