STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-19287 HHS
Case [redacted]

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] was represented by his wife, [redacted] at hearing. [redacted], represented the Department. [redacted] was present as a Department witness. [redacted], also appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly authorize 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 Medicaid beneficiary who applied for Adult Home Help Services (HHS). (Uncontested)

2. The Appellant resides with his wife. (Uncontested)

3. On [redacted] the Adult Services Worker conducted an in–home comprehensive assessment. As a result of the assessment, she authorized Home Help Assistance payments in the amount of [redacted] per month. (Uncontested)

4. The Adult Services Worker determined the Appellant required assistance with bathing, grooming, dressing, eating, medication, laundry, shopping, mobility, housework and meal preparation. (Uncontested)

5. The worker ranked the Appellant a score of 2 for housework and mobility, indicating some assistance was needed, however, not at a compensable level. (Uncontested)

6. The worker found the Appellant's wife is able to perform some of the tasks for which the Appellant requires assistance. (Uncontested)

7. The Appellant's wife is a legally responsible adult, available and able to provide care to the Appellant. (Documents and testimony regarding employment)

8. On [redacted] the worker sent an Approval Notice informing the Appellant his HHS Payment was authorized in the amount of [redacted] per month. (Department exhibit)

9. The Appellant requested a formal, administrative hearing [redacted] (Department exhibit)

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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HOME HELP SERVICE PROVIDERS

Provider Selection

The customer has the right to choose the home help provider(s). As the employer of the provider, the customer has the right to hire and fire providers to meet individual personal care service needs.

The customer may receive FIA payment for home help services from **qualified** providers only.

The determination of provider qualification is the responsibility of the adult services worker.

Upon request, the adult services worker should assist the customer in obtaining a qualified provider.

The local office may maintain a resource file of qualified providers willing to assist HHS customers. The file may include such information as:

- Type of customer the provider is willing to work with;
- Training the provider has participated in;
- Past work experience;
- Hours the provider is willing/available to work;
- Type of services the provider is willing to perform.

> **Do not authorize HHS payments to a responsible relative or legal dependent of the customer**.
>
> *Adult Services Manual (ASM) 4-1-2004*

Policy establishes the Department cannot pay for a personal care or chore provider if the beneficiary has a legally responsible relative available and able to provide the care the beneficiary may need. In this case the Department asserts the Appellant's wife is able to provide much of the care the Appellant requires. Some payment was approved due to the assertion from the Appellant's spouse that she is employed full time. At hearing, a letter from the Appellant's purported employer indicates she has employed the Appellant's spouse as a babysitter. The purported employer is also a DHS client with income reporting requirements. Uncontested evidence was submitted indicating the purported employer does not report income to the Department of Human Services. It could not be ascertained how or if the Appellant's spouse is being compensated, since the purported employer is receiving public assistance and reports no income to the State.

The Appellant's spouse indicated she leaves for work at 7:30 a.m. and her employer lives a few bocks away. The letter from her purported employer indicates she works 9-5. No credible explanation was provided regarding why it would take 1 ½ hours to travel a couple of blocks. The Appellant's spouse did state she makes very little for babysitting and it is really just a few dollars. The Appellant's position is that she is not available to provide care because she is employed full time.

This ALJ reviewed the evidence of record concerning the HHS application and circumstances for the Appellant. It is uncontested he suffers from a traumatic brain injury and is disabled. There was uncontested testimony from his wife that he requires supervision and monitoring, neither of which are compensable under the HHS program. It is further uncontested he is legally married. A review of the evidence of record supports a finding the Appellant's spouse is able and available to provide care. This ALJ finds the evidence of her employment is quite sparse, inconsistent and insufficient to establish she is unavailable. It is sparse in that there is no evidence of compensation, i.e. no pay stubs, reported income or records. It is inconsistent in that she testified to leaving for work between 7:30 AM and 8:30 AM but her "employer" indicated she worked at 9:00 AM. The Appellant's testimony is that her employer lived a couple blocks over. No reasonable person can believe it takes 1 – 1 ½ hours to travel a few blocks. The evidence of record fails to establish she is unavailable to provide the care the Appellant needs beyond what was authorized by the worker because the care needed can be provided during non-working hours. The Appellant's testimony regarding compensation was that it was very little (a few dollars), thus is inconsistent with any claim of 6 day per week, full time (or full day) unavailability. The Appellant's testimony cannot be given sufficient weight to justify a reversal of the Department's determination for all the above stated reasons.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department's determination was based upon an adequate assessment and is supported by policy.

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

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

cc: [redacted]

Date Mailed: 6/26/2009

***** 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.