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. 2009-35403 HHS
Case No. [redacted]9

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 at the hearing. [redacted], Appellant's provider, appeared and testified on behalf of Appellant. [redacted] appeared as a witness for Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker, 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 Medicaid recipient who receives home help services.

2. Appellant was diagnosed with renal failure, chronic obstructive pulmonary disease (COPD), pulmonary vascular disease, diabetes, heart problems, arthritis, emphysema, asthma, and diabetic neuropathy. (Exhibit 1, p. 14)

3. Appellant is not considered non-ambulatory, but uses a wheelchair. (ALJ I)

4. Appellant had been receiving home help services for assistance with activities of daily living (ADLs) and Instrumental Activities of Daily Living (IADLs), and it was determined that she had complex care needs which

required a home help services payment for assistance with wound care for 15 minutes, 5 days per week. (Exhibit 1, pp. 10 & 12)

5. The responsibility of assisting Appellant with wound care was shared between Appellant's home help services provider and visiting nurses. (Exhibit 1, pp. 11 & 13)

6. Appellant submitted an updated completed Medical Needs form (DHS-54A) from an MA enrolled provider which indicates the following: Appellant needs assistance with bathing, grooming, transferring, mobility, taking medications, meal preparation, shopping, laundry, and housework; and Appellant will need assistance with her personal care activities for one year. (ALJ I)

7. On [redacted], Appellant's Adult Services Worker spoke with one of Appellant's visiting nurses who informed the worker that the time it takes to care for Appellant's wound is 15 minutes, and Appellant should receive wound care 2 to 3 times per week.

8. Appellant's Adult Services Worker determined that Appellant's home help services payment must be reduced on the basis that she no longer needs assistance with dressing, and she needs assistance with wound care only 3 days per week instead of 5. (Exhibit 1, p. 12)

9. Appellant's new monthly home help services payment was determined to be [redacted]. (Exhibit 1, p. 12)

10. After receiving the updated Medical Needs form and the information regarding the assistance that Appellant needs with wound care, on [redacted] Appellant's Adult Services Worker sent two negative action notices to Appellant, informing her that her home help services payment would be reduced to [redacted]; and the other notice stated that the payment would be reduced to [redacted] (Exhibit 1, pp. 4 & 7)

11. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the reduction of 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 2008-002-9-1-2008

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 2008-002-9-1-2008

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 2008-002-9-1-2008

RESPONSIBLE RELATIVE

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

ASM 361; INDEPENDENT LIVING SERVICES PROGRAM OVERVIEW ASB 2007-6-1-2007

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.

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; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES ASB 2008-002 9-1-2008

In this case, Appellant requested a hearing to protest the reduction of her home help services. Appellant made it clear in her hearing request that she was not given a reasonable explanation for the reduction in her home help services payment.

Appellant had been receiving home help services for assistance with activities of daily living (ADLs) and Instrumental Activities of Daily Living (IADLs), and it was determined that she had complex care needs which required a home help services payment for assistance with wound care for 15 minutes, 5 days per week. Appellant's Adult Services Worker determined that Appellant's home help services payment must be reduced on the basis that she no longer needs assistance with dressing, and she needs assistance with wound care only 3 days per week instead of 5.

This Administrative Law Judge agrees with the worker's eligibility determination or reduction in services based on the fact that Appellant's updated medical needs form does not certify a need for assistance with dressing, and the information that the worker

received from one of Appellant's visiting nurses regarding Appellant's wound care. Further, Appellant's provider testified at the hearing that Appellant no longer needs assistance with wound care. Therefore, the worker needs to reassess Appellant's eligibility for assistance with wound care based on this reported change in circumstance at the hearing. 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.

It does appear that Appellant received incorrect Adequate Negative Action Notices from the Department. As evidenced by Exhibit 1, p. 12, Appellant new home help services payment was determined to be [redacted]. On [redacted], Appellant's Adult Services Worker sent two negative action notices to Appellant. One stated that Appellant's home help services payment would be reduced to [redacted]; and the other stated that the payment would be reduced to [redacted] effective [redacted]. The Department needs to send Appellant proper notice of her new reduced home help services payment amount with the effective date of the negative action. An Advance Negative Action period is required by the law and policy **before** terminating, suspending or reducing a Medicaid-covered benefit or service.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined that Appellant's home help services must be reduced.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED. However, the Department must send Appellant proper notice of the negative action which reflects the correct home help services payment amount and effective date of the negative action.

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

cc: [redacted]

Date Mailed: 10/27/2009

***** 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.