

**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. 2009-9047 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 _____, _____ was represented by his daughter, _____, _____ represented the Department. _____ was present as a Department witness. _____, also appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly terminate 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 has participated in Adult Home Help Services.
2. The Appellant resides with his wife, aged _____
3. On _____ the Department sent an Adult Services Worker to the Appellant's home to conduct a comprehensive assessment following case transfer from another office.
4. The Appellant's wife is a legally responsible adult and able to provide care to the Appellant.

5. The Adult Services Worker sent a negative action notice to the Appellant indicating his Home Help Services (HHS) case would be terminated, effective [REDACTED]
[REDACTED]
6. The Appellant appealed the determination on [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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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.

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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 any care the Appellant requires. The Department presented evidence the Appellant is married, resides with his wife and his wife would provide any care he may need.

The Appellant contested the assertion that his wife is able to provide the care. The claim is that she is too physically disabled to provide the care he needs. The proofs submitted were reviewed by this ALJ. This ALJ found the Appellant's testimony (through his daughter) regarding his wife's medical condition was self-serving, lacked credibility and does not rely on it to make relevant factual findings. The medical documentation submitted was read. There is a letter from a doctor that asserts the Appellant's wife is unable to provide for the Appellant's needs, however, this letter does not have any accompanying supporting medical evidence. The reason given for the conclusion from the doctor is that she suffers from severe arthritis of knees and spine; however, the supporting MRI contradicts this claim. The MRI study findings do not note any severe arthritis or significant findings such that the Appellant's wife would be found unable to attend to not only her own needs but those of her husband. The evidence provided by the Department regarding the Appellant's wife's apparent ability to provide for her husband's needs is found more credible by this ALJ. The worker testified the Appellant's wife walks unassisted, is able to and does drive. She has a valid driver's license. Additionally, the provider log evidenced only occasional service was provided to the couple; thus an assertion that physical assistance is required in order to maintain independent living is contradicted by the evidence on the log. She was not dependent on services and appeared able to meet those of her husband. The worker's determination was resultant from the comprehensive assessment performed at the home call. The worker correctly applied the policy prohibiting payment to a legally responsible relative.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department has properly terminated the home help assistance payments to the Appellant because he has a legally responsible relative available to provide any care he may need.

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

[REDACTED]
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Decision and Order

cc:

[REDACTED]

Date Mailed: 3/24/2009

***** 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.