

**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. 2010-36084 HHS

Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████ appeared on his own behalf. ██████████, represented the Department.

██████████ (worker), and ██████████, were present as Department witnesses.

ISSUE

Did the Department properly terminate Home Help Services (HHS) 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 Medicaid beneficiary who was receiving Adult HHS.
2. The Appellant lives with his chore provider, ██████████. (Exhibit 1, page 8)
3. The Appellant has been diagnosed with HIV, a herniated disc, fracture of his right foot in ██████████, and cardio arrhythmia. (Exhibit 1, page 11)
4. On ██████████, the worker conducted a six-month assessment with the Appellant for continuing eligibility for HHS. (Exhibit 1, page 8)

5. As a result of the information gathered from the Appellant at the assessment and her observations, the worker determined that the Appellant no longer needs HHS. (Exhibit 1, page 8)
6. On ██████████ the Department issued an Advance Negative Action Notice, advising the Appellant that his HHS payments would terminate, effective to ██████████. (Exhibit 1, pages 4-7)
7. The Appellant requested a formal, administrative hearing on ██████████. (Exhibit 1, page 3)

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.

The purpose of HHS is 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.

Adult Services Manual (ASM 363) 9-1-2008, pages 2-5 of 24 addresses the issue of assessment:

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 client in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the client'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 redetermination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department 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 client'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
- Laundry
- Light 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.

Time and Task

The worker will allocate time for each task assessed a rank of 3 or higher, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a guide. The RTS can be found in **ASCAP** under the **Payment** module, Time and Task screen.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 hours/month for laundry
- 25 hours/month for meal preparation

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements.

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 client 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 client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client 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 client.
- 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 client 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 client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for same time period).

Adult Services Manual (ASM 363) 9-1-2008, Pages 2-5 of 24

The Appellant was authorized to receive HHS for the tasks of housework, laundry, shopping, and meal preparation. He was originally ranked at a level three, meaning he needed some assistance with performing those tasks.

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On ██████████, the worker completed a six-month review in accordance with Department policy. The worker testified that the Appellant told her that he was feeling better. She further stated that during this visit, the Appellant walked without difficulty or assistive device, he was able to get up and down without difficulty, and he acknowledged that he could do his own laundry but expressed a need for help with the other IADLs because of foot pain. The worker provided the Appellant with a new 54-A medical needs form to be completed by his physician. However, that form was never returned to her. The worker testified that she also saw the Appellant in her office on ██████████, and her impressions were the same.

The worker further testified that based on the information she was provided by the Appellant at the time of the assessment and her own observations, she determined that the Appellant no longer qualified for HHS payments. She stated that she believes that the Appellant's current level of need is a level one, meaning he needs no assistance with IADLs.

The Appellant disagrees with the worker's determination and testified that he does need assistance with IADLs. He stated that he has good days and bad days, but his overall medical condition has not changed. He stated that the worker saw him on a good day, but on bad days, he cannot even get out of bed. He acknowledged that he probably could perform the IADLs on his good days. But he also noted that he probably should not try to because of his shortness of breath and fatigue. He further stated that he feels more comfortable attempting the tasks when his chore provider is there.

The Appellant did not meet his burden of proving, by a preponderance of evidence, that the Department improperly terminated his HHS. The Appellant stated that he is capable of performing the IADLs on his good days. Therefore, eligibility for continuing HHS was not supported.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has properly terminated HHS payments for the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

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cc:



Date Mailed: 8/20/2010

***** 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.