STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-572 HHS
Case No. [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 [redacted].

[redacted], represented the Department of Community Health. [redacted], appeared as a witness on behalf of the Department.

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 Medicaid beneficiary who participates in the Home Help Services (HHS) program.

2. The Appellant is [redacted] old. She is diagnosed with epilepsy, obesity, torn meniscus and herniated discs in her spine. She is ambulatory, sometimes using a cane for assistance.

3. The Appellant receives payment assistance for the tasks of bathing, housework, laundry, shopping and meal preparation.

4. The Appellant had been receiving payment assistance for the self care tasks of grooming, dressing, eating and mobility prior to her most recent comprehensive assessment.

5. The Appellant had an in office interview in [redacted]. The worker determined at the interview the Appellant did not require physical assistance with eating, mobility, grooming, or dressing and was receiving limited assistance bathing.

6. The worker removed payment for grooming, dressing and eating following the assessment. She reduced payment assistance for bathing.

7. The Appellant was notified of the reductions in an Advance Negative Action Notice [redacted].

8. The Appellant requested a hearing [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.

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.

Adult Services Manual (ASM) 9-1-2008

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.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-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 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 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
- 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.

Time and Task

The worker will allocate time for each task assessed a rank of 3 or higher, based on the 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. When hours exceed the RTS rationale must be provided.

IADL Maximum Allowable Hours

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

- Five hours/month for shopping
- Six hours/month for light housework
- Seven 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. If there is a need for expanded hours, a request should be submitted to:

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 the 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.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. Unable means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS-54A.

- 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 the same time period).

Adult Services Manual (ASM) 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).

Adult Services Manual (ASM) 9-1-2008

In this case the Appellant sought to contest the functional assessment upon which the reductions are based. The Department's worker testified functional assessment took place during an in office interview that included the provider. The provider indicated what tasks she performed to aid her and she did not indicate she assisted with eating, dressing or grooming. She stated she aids with meal preparation and assists her get into and out of the bathtub. The worker thereafter reduced the payment assistance for bathing to reflect the very limited physical assistance rendered for that task and eliminated the payment assistance for grooming, dressing, eating and mobility.

The Appellant's evidence included a claim that the provider has to be present when her mother eats and a lot of her trouble stems from a seizure she experienced [redacted] earlier. The provider indicated she did not assist her mother with transferring and arrives daily at 10 a.m. She stated her mother toilets without assistance. When it was pointed out her mother is toileting without aid, thus she could dress herself without aid, she then stated she has to help her mother pull her pants up for dressing and that she does not lower them all the way when toileting, thus she does not require assistance for toileting. When asked why her mother cannot dress herself, she stated she cannot pull her pants on alone. She further stated her mother does not suffer diabetes, yet asserts she eats separately from her father, who resides in the same house. The provider asserted the worker did an inadequate assessment of her parents during the interview.

The Appellant's husband has a companion case, which also had a hearing scheduled before this ALJ on the same date. Evidence was taken regarding the Appellant's husband's physical status at that hearing. No evidence was presented that could have established the Appellant's spouse is unable to assist the Appellant pull her pants on, if

she is actually unable to do it for herself. Nor was any evidence presented establishing the Appellant's husband is unable to assist the Appellant get into and out of the bathtub.

The reductions implemented in the case are based upon the information provided the worker by the provider. This ALJ finds the worker's assessment adequate to support the reductions made and in accord with Department policy. Not only does the material evidence support the reductions implemented, but additional reductions as well. Policy does not support providing payment assistance at any level for bathing because the Appellant is married and her spouse is able and available to assist her with the task of bathing, at least. The evidentiary record in this matter is more supportive of further assessment of the Appellant's spouse for the purpose of determining his ability or inability to assist his wife, however this ALJ will not order that it be done at this time.

There is evidence of record indicating the Department's worker implemented the pro-rating policy to reflect the household composition of 3 adults. No evidence was presented to support a departure from that policy standard. In fact, the testimony presented on behalf of the Appellant not only lacks persuasive effect, her credibility is severely damaged by the claims that she has a daughter who provides for her needs separately from the daughter who is allegedly taking care of her husband, who lives in the same household. The Appellant would have this ALJ believe that two different daughters provide care for each parent separately; including cleaning the shared house separately, preparing meals separately and shopping for food separately. This is a preposterous claim that is not supported by common sense or credible evidence. No reasonable person would believe this arrangement is necessary or appropriate. It has the appearance of an income stream for the family, rather than a vital service program that is preventing the Appellant from having to reside in an institution or suffer deleterious health effects due to an actual inability to provide for her own care. It has the effect of damaging the credibility of all the testimony presented on behalf of the Appellant.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly reduced the Appellant's HHS payments in the areas of bathing, household chores, shopping, laundry and meal preparation. Furthermore, the Department properly eliminated payment assistance for eating, mobility, grooming and dressing.

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

cc: [redacted]

Date Mailed: 12/17/2009

***** 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.