STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-30690 HHS
[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]. The Appellant was present. He was represented by his chore provider, [redacted]. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Supervisor, appeared as a Department witness.

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 a Medicaid beneficiary who was receiving Adult Home Help Services (HHS).

2. The Appellant has been diagnosed with rheumatoid arthritis, broken discs in his neck, asthma, neuropathy, hypercholesterol, shortness of breath, and chest pain. (Exhibit 1, page 21)

3. [redacted] is the Appellant's chore provider. (Exhibit 1, page 17)

4. On [redacted], an Adult Services Worker conducted an in-home assessment with the Appellant for continuing eligibility for HHS. (Exhibit 1, page 19)

5. On [redacted], the worker issued an Advance Negative Action Notice, reducing the Appellant's HHS payments to [redacted] effective [redacted], because the worker had determined that the Appellant no longer needed assistant with mobility. In addition, the worker advised the Appellant that it had been discovered that he had a wife, and that she was required to complete a DHS 54-A medical needs form by [redacted], to determine if she was capable of assisting the Appellant. (Exhibit 1, pages 11-14)

6. On [redacted], the worker issued a second Advance Negative Action Notice, advising that the Appellant's services would be terminated effective [redacted], if the medical needs form was not completed.

7. The Appellant requested a formal, administrative hearing on [redacted] (Exhibit 1, page 3)

8. As of the date of the hearing, the Department had not received a completed medical needs form from the Appellant's wife.

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.

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.

  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 same time period).

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

The Adult Services Supervisor testified that after supervisory review of this case, the Department became aware that the Appellant was married. On [redacted], the worker sent out an Advanced Negative Action Notice, requesting that a DHS-54A medical needs form be completed by the Appellant's wife doctor to determine her ability to assist him. The medical needs form was not completed. The Adult Services Supervisor further testified that without documentation that the Appellant's wife was disabled or unavailable, the Department determined that she is responsible to care for the Appellant.

The Appellant disagrees with the determination that his wife is available and is able to provide the needed care services. The Appellant's representative stated that the Appellant and his wife have been estranged for several years and that the Appellant does not even know his wife's whereabouts. The Appellant's representative further stated that the Appellant is not able to obtain a divorce from his wife because his religion forbids it.

The Department properly considered the availability and ability of the Appellant's wife to provide care for the Appellant. The Adult Services Glossary defines a responsible relative as a person's spouse or a parent of an unmarried child under age 18. Adult Services Glossary (ASG Glossary) 12-1-2007, Page 5 of 6. The Appellant's wife meets the definition of a responsible relative. Under Department policy, HHS for the Appellant could only be authorized for those services or times which the responsible relative is unavailable or unable to provide. The policy notes that 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 care giving. These disabilities must be documented/verified by a medical professional on the DHS-54A. Adult Services Manual (ASM 363) 9-1-2008, Page 5 of 24. No documentation was submitted to the Department to verify that the Appellant's wife is either unavailable or unable to care for the Appellant.

The Appellant did not meet his burden of proving, by a preponderance of evidence, that the Department did not properly terminate his HHS payments. Based on the information available to the Department at the time of the termination, 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

cc: [redacted]

Date Mailed: 6/9/2010

***** 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.