

**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. 2010-575 HHS
Case 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 ██████████. ██████████ was represented by ██████████.

██████████, represented the Department of Community Health. ██████████, 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 receives payment assistance for the tasks of housework, laundry, shopping and meal preparation.
3. The Appellant is a ██████████ male who resides with his wife and adult son in his own home. He is diagnosed with the following medical issues: irregular

- heart beat, high blood pressure, prostate cancer (in remission for █ years), diabetes and acid reflux. He had his gall bladder removed in █.
4. The Appellant's case was recently transferred to a different worker in his county.
 5. The Department's worker conducted an assessment of the Appellant's functional status during an in office interview in █. The only change made in the Appellant's case was a reduction in payment assistance for instrumental activities of daily living based upon the Department policy of pro-rating payments for those residing in shared households.
 6. The Appellant's functional ranks were not changed as a result of the in office interview. No other reductions were implemented.
 7. The Appellant was notified of the reductions in an Advance Negative Action Notice █.
 8. The Appellant requested a hearing █.

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 that is documented in his case plan. According to uncontested evidence from the Department witness, the functional assessment was not changed as a result of the in office interview conducted in ██████████, nor was a reduction implemented as a result of change in functional assessment. The Appellant asserts he requires assistance bathing, in addition to the other tasks he is already compensated for. The case documentation reflects the Appellant has never received payment assistance for bathing. The worker observed the Appellant demonstrate with his arm why he believes he cannot perform the bathing function unassisted. She noted the Appellant asserts his daughter assists him bathing. She determined he is able to still bathe himself without physical assistance. She did not authorize payment assistance for the task of bathing, following her personal observations at the interview. Additional evidence of uncontested circumstances indicates the Appellant has a driver's license. He walks unassisted. There is no medical documentation establishing a severe physical limitation of any kind. While the Appellant is not without medical issues, there is no evidence his medical issues result in physical limitations. Specifically, there is no evidence of why having high blood pressure, without further documentation, physically limits the Appellant's ability to prepare his own meals or bath. Nor would the medical condition resultant from having an irregular heartbeat provide evidence of why the Appellant cannot do laundry, shop, make meals or bath himself unassisted. He is not required to perform the tasks uninterrupted or on any particular time table. He can rest and take breaks if necessary or tired. Without more information explicitly establishing how the

medical issues the Appellant does have physically limits his ability to care for himself, the worker's observations of his abilities are found credible to this ALJ.

The only reductions implemented in the case are based upon the uncontested fact the Appellant resides in a household of 3 adults. He is not entitled to have payment assistance that benefits other members of the same household according to the Department Policy. He failed to present any persuasive evidence of an inability to bath unassisted. In fact, the testimony presented on behalf of the Appellant not only lacks persuasive effect, his credibility is severely damaged by the claims that he has a daughter who provides for his needs separately from the daughter who is allegedly taking care of his wife, 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. The fact that his alleged provider works full time and lives in another city is good evidence he is able to take care of his basic needs without her assistance. It is unlikely she is providing the assistance he asserts he needs in the amount he asserts he needs because of the time constraints of working full time and commuting not only to work and back but to her parents' house and back. Additionally, another daughter is allegedly coming to the same house every day. No reasonable person would believe such an 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 his own care.

The policy implemented by the worker is recognition of the fact that in most cases, certain tasks are performed that benefit all members who reside in the home together, such as cleaning, laundry, shopping and meal preparation. Normally, it is appropriate to pro-rate the payment for those tasks by the number of adults residing in the home together. There was no evidence presented it was not appropriate to do so in this case.

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 household chores, shopping, laundry and meal preparation.


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Decision and Order

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:



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.