STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2012-16382 HHS

[redacted] [redacted]

Appellant

_____/

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] represented herself. [redacted] [redacted]. were present on her behalf.

[redacted], Appeals and Review Officer for the Department of Community Health, represented the Department. [redacted], Adult Services Supervisor, and [redacted], Adult Services Worker 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 has been receiving Adult Home Help Services.

2. The Appellant is diagnosed with hydrocephalus, hemparesis, left sided weakness, memory problems, history of stroke, cerebral palsy, and slow, unbalanced gait with left leg dragging. She is [redacted] years old.

3. The Appellant receives SSI income and resides in her own home with a teenaged son and daughter.

4. The Appellant has been receiving payment assistance for instrumental activities of daily living only, though the HHS program. Specifically, she has received payment assistance for medication assistance, housework, laundry, shopping and meal preparation.

5. The Department's worker made a home call [redacted], to perform a comprehensive assessment.

6. The Appellant informed the worker she required assistance getting in and out of the bathtub at the [redacted], comprehensive assessment. She further informed the worker she required help dressing.

7. The Department's worker asked the Appellant why she had just asked for the bathing and dressing assistance now. She was informed by the Appellant she had just thought of it.

8. The Department's worker completed the comprehensive assessment at the [redacted], home call. Her narrative notes indicate that she concluded the Appellant could be assisted "in and out of the tub by her children since she just thought about it," thus was no longer eligible for participation in the program.

9. On [redacted] the Department's worker spoke with the Appellant's provider, who informed her he helps her around the house, in and out of the tub, with housework, laundry, and shopping. He reported the Appellant falls a lot.

10. The Department sent the Appellant an Advance Negative Action Notice [redacted], informing her of the termination of HHS benefits, effective [redacted] The reason printed on the Notice is "you are not eligible for home help services."

11. 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.

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:

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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 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).
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> *Adult Services Manual (ASM) 9-1-2008*

The Department issued an Interim Policy Bulletin effective [redacted]. It states in pertinent part:

> Home Help Eligibility Criteria
>
> To qualify for home help services, an individual must require assistance with at least one activity of daily living (ADL) assessed at a level 3 or greater. The change in policy must be applied to any new cases opened on or after October 1, 2011, and to all ongoing cases as of October 1, 2011.
>
> Comprehensive Assessment Required Before Closure
>
> Clients currently receiving home help services must be assessed at the next face to face contact in the client's home to determine continued eligibility. If the adult services specialist has a face to face contact in the client's home prior to the next scheduled review/redetermination, an assessment of need must take place at that time.
>
> Example: a face to face review was completed in August 2011; the next scheduled review will be in February 2012. The specialist meets with the client in his/her home for a provider interview in December 2011. Previous assessments indicate the client only needing assistance with instrumental activities of daily living (IADL). A new comprehensive assessment must be completed on this client.
>
> If the assessment determines a need for an ADL at level 3 or greater but these services are not paid for by the department, or the client refuses to receive assistance, the client would continue to be eligible to receive IADL services.
>
> If the client is receiving only IADLs and does not require assistance with at least one ADL, the client no longer meets eligibility for home help services and the case must close after negative action notice is provided.
>
> *DHS Interim Policy Bulletin 10/1/11*

In this case the evidence of record establishes the worker did conduct a comprehensive assessment at the [redacted] home call. She was informed the Appellant continues

treatment with [redacted] for hydrocephalus, past cva, hemparesis, left arm weakness, right arm tingling, memory problems, numbness, slow gait, lack of balance and dropping things. She continues to treat with a neurologist. She was informed by the Appellant she requires assistance in and out of the bathtub and with dressing. She said she dresses slowly. It was noted in the narrative it took a long time for the Appellant to answer the door. She asked the Appellant why she needed help dressing and bathing now. She was informed by the Appellant she had just thought about it. The worker noted in the narrative "client has no problems walking around the home with her limp. Can also manage stairs." Finally, she wrote "clients request for additional services are being denied. Client has 2 teenage children to help her in/out of the tub since she just thought about it." At hearing the worker responded to the question from this ALJ of whether she had determined the Appellant could receive the help she does require from her children. She answered yes. The worker testified she had never gotten the medical needs form (DHS 54) returned that she had sent.

At hearing the Appellant stated she still required assistance. She said she is weak, she has trouble walking, keeping her balance. She said her provider is still providing her chores. She testified if the task requires 2 hands she is unable to do it. She also stated she had fallen a few times.

This ALJ finds the evidence of record regarding what the Appellant's medical condition is, in conjunction with her testimony that she requires help in and out of the bathtub, is credible evidence she needs help with an activity of daily living. According to the functional ranks and definitions contained in the appendix, a person who requires assistance in and out of the bathtub should be ranked a 3. This would not obligate the Department to authorize payment assistance for this task; however, even under the new policy, if she requires this assistance, she is still eligible for payment assistance for her instrumental activities of daily living. The worker did not apply the new policy correctly. Her own notes indicate that the Appellant can receive the physical, hands on assistance she requires with an activity of daily living from her children. She did not make a determination the Appellant does not actually require the help she asked for. She determined she could obtain it from another source. She thereafter informs the Appellant in the Notice she is not eligible for Home Help Services. This is not supported by policy. The policy indicates a beneficiary who requires physical assistance with an activity of daily living but is refusing it or it is not being provided through the HHS program is still eligible for payment assistance with instrumental activities of daily living.

The policy clearly states hands on assistance is required for an activity of daily living in order to continue receiving assistance with instrumental activities of daily living. It does not require the hands on assistance be provided by the program, thus eligibility cannot properly be terminated on the basis that the assistance in and out of the tub the Appellant gets from her children renders her ineligible for other services. Here, the comprehensive assessment conducted was adequate; however, the worker's decision to terminate the payment assistance for Home Help Services because the Appellant's children could help her in and out of the bathtub was improper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department has improperly terminated the Home Help Services benefits of the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 03-1-12

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.