STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2012-21801 HHS
Case No. [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] was represented by her daughter, [redacted].

[redacted], Appeals and Review Officer for the Department of Community Health, represented the Department. [redacted], Adult Services Worker was present as a Department witness.

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 for [redacted] years.

2. The Appellant is diagnosed with coronary artery disease according to the most recent DHS-54A (Medical Needs) form completed by her doctor on or about [redacted].

3. The Appellant is [redacted] years old.

4. The Appellant has been receiving assistance with housework, shopping, laundry and meal preparation through the Home Help Services program. She resides with her daughter, who is her provider.

5. The Appellant formerly received payment assistance for additional tasks, dressing, bathing and grooming. Those were terminated by a previous worker after speaking with the Appellant's doctor and completion of a comprehensive assessment.

6. The Appellant's HHS case was transferred to the currently assigned worker, who completed his first home call and comprehensive assessment in [redacted].

7. The Department Specialist determined the Appellant's needs had remained the same as in the most recent assessment and that she did not have a need for physical assistance with any activity of daily living as defined in the Department's HHS policy.

8. The Department of Human Services enacted new policy, via an interim policy bulletin effective October 1, 2011, restricting eligibility for HHS payment assistance to those who require physical assistance with a listed activity of daily living. The policy eliminated assistance for those program beneficiaries and applicants who only require physical assistance with an instrumental activity of daily living.

9. The Department sent the Appellant an Advance Negative Action Notice [redacted], informing her of the termination of HHS benefits, effective [redacted].

10. 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 October 1, 2011. 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. The Department evidence included direct discussion with the Appellant's daughter, who is her provider. The worker testified he had been informed the Appellant requires complete assistance with bathing, grooming, dressing and all instrumental activities of daily living. He was further informed the Appellant is assisted down the stairs in her home by her daughter. Finally, he was informed the Appellant can eat and toilet without assistance. He stated the Appellant's daughter stated the Appellant does not speak English and the provider did the talking at the assessment. The worker stated it was his first visit and assessment of the Appellant. He had discussed the case with the previously assigned worker and read all the documentation. He noted his previous worker had made a collateral contact to the Appellant's doctor, who insisted the Appellant was able to perform her own activities of daily living and only needed assistance with instrumental activities of daily living. He further testified the previous worker told him that when she made a home call she saw

the Appellant walk down the stairs of her home unassisted in order to answer the door. He determined the assertions from the daughter/provider were not reliable with regard to the actual need for physical assistance with activities of daily living. He assessed the Appellant as independent for those tasks, resulting in ineligibility for continuation in the program. He sent a negative action notice and was informed by the Appellant's daughter it had not been received so he sent a second one. He added he has evaluated other HHS participants, determined they did have a need for assistance with activities of daily living and is confident he has made an accurate assessment in this case.

At hearing the Appellant's daughter reported the Appellant is not bedridden but she does everything for her because she needs it. She said her mother is able to eat and toilet unassisted. She walks with aid of a walker or cane. She disputed the previous worker's ability to see her mother come down the stairs and stated the workers were making her feel like she was trying to get over or take advantage of the system. She said she has to wash her mother's body, hair, get her in and out of the tub, dress her and cut her nails for her. She makes all her meals and performs the other instrumental activities of daily living as well. She said her mother is able to slowly walk to the bathroom and toilet herself, as well as eat. Se did not explain why her mother can use a walker and cane and cut her own food but cannot put her own clothing on, nor fold laundry. She did not explain the apparent discrepancy between what her doctor informed the worker and what she claims she must do for her mother. This ALJ notes that simply because a task is performed on behalf of another person that does not mean it is medically necessary for it to be done. The Appellant must show it is medically necessary to have the tasks performed for her or at least with assistance in order to establish eligibility. The Appellant provided no additional medical documentation to support her claim her mother is medically unable to bathe, dress or groom herself. Her testimony alone is insufficient to persuade this ALJ that the doctor is wrong and the worker is wrong.

The evidence of record does not establish Department error. This ALJ did not find the testimony presented on behalf of the Appellant credible. The eligibility requirements for this program are more stringent than before. The Department no longer provides Home Help assistance benefits to those who require physical assistance with instrumental activities of daily living only, as evidenced by its new policy. The Appellant has not established she meets eligibility criteria under the new policy, thus no relief may be granted as a result of this hearing.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department has the support of policy for its termination of the Home Help Services benefits of the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 4/20/2012

***** 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.