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

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-33948 HHS

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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] appeared on his own behalf. [redacted], represented the Department (DHS). [redacted], appeared as a witness for the Department. [redacted] was present on behalf of the Department.

ISSUE

Did the Department properly deny Appellant Home Help Services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a Medicaid beneficiary.

2. Appellant is a [redacted] lower left leg amputee who is legally blind as a result of suffering diabetic retinopathy.

3. The Appellant applied for DHS Home Help Services. As part of the application process, the DHS Adult Services Worker sent out a Medical Needs form DHS-54A for the Appellant's current physician to fill out and return.

4. The Appellant's physician completed and signed the Medical Needs form and

returned it to the Adult Services Worker. The form is ambiguous. The worker observed that the physician stated both yes and no when attempting to indicate if the Appellant has a medical need for assistance.

5. The worker determined the form did not certify a medical need, thus denied the application and sent a negative action notice.

6. On [redacted], the Department received Appellant's Request for 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 Social Welfare Act, 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.

MISSION STATEMENT
The purpose of independent living services (ILS) is to provide a range of support and assistance related services to enable individuals of any age to live safely in the least restrictive setting of their choice.

Our vision of independent living services is to:
- Ensure client choice and personal dignity.
- Ensure clients are safe and secure.
- Encourage individuals to function to the maximum degree of their capabilities.

To accomplish this vision, we will:
- Act as resource brokers for clients.
- Advocate for equal access to available resources.
- Develop and maintain fully functioning partnerships that educate and effectively allocate limited resources on behalf of our clients.

PROGRAM DESCRIPTION
Independent living services offer a range of payment and nonpayment related services to individuals who require advice or assistance to support effective functioning within a home or other independent living arrangement.

Nonpayment Services
Nonpayment independent living services are available, without regard to income or assets, upon request to any person who needs some form of in-home service. Nonpayment services include all services listed below except personal care services:

- Information and referral.
- Protection (for adults in need of a conservator or a guardian, but who are not in any immediate need of protective intervention).
- DHS counseling.
- Education and training.
- Health related.
- Housing.

Home Help Payment Services
Home help services (HHS, or personal care services) are non-specialized personal care service activities provided under ILS to persons who meet eligibility requirements.

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.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)
- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)
- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Housework.

Expanded Home Help Services
EHHS can be authorized for individuals who have severe functional limitations which require such extensive care that the services cannot be purchased within the maximum monthly payment rate.

BEST PRACTICE PRINCIPLES
Independent living services will adhere to the following principles:

- Case planning will be person-centered and strength-based.
- Clients will be given a wide range of options to enable informed decision making.
- Client choice will be encouraged and respected; choices will be balanced with safety and security needs.
- All ILS clients will become self-advocates and will participate in case planning.
- Monitor client satisfaction by actively involving clients in evaluating the quality of services delivered to them.
- Monitor service delivered by caregivers to ensure client needs are properly met.
- Monitor caseloads to ensure consistency of service delivery.
- Service plans will be built on the principle of continuous quality improvement.
- Services should be least intrusive, least disruptive and least restrictive.
- Services must recognize the role of the family, directing resources toward the family in their role as caregiver. **However**, if the interest of the family and the client compete, the client's interest is primary.
- A broad range of social work practices will be employed, focused on person-centered services planning.

PERSONCENTERED PLANNING AND ADVOCACY
The ILS specialist views each client as an individual with specific and unique circumstances, and will approach case planning wholistically, from a person-centered, strength-based perspective.

Person-centered, strength-based case planning focuses on:

- Client as **decision-maker** in determining needs and case planning.
- Client **strength and successes,** instead of problems.

- Client as their **own best resource.**
- Client **empowerment.**
- The ILS specialist's role includes **being an advocate** for the client.

As advocate, the specialist will:

- Assist the client to become a self-advocate.
- Assist the client in securing necessary resources.
- Inform the client of options and educate him/her as to how to make the best possible use of available resources.
- Promote services for clients in the least restrictive environment.
- Promote employment counseling and training services for developmentally disabled persons to ensure **inclusion** in the range of career opportunities available in the community.
- Participate in community forums, town meetings, hearings, etc. for the purpose of information gathering and sharing.
- Ensure that community programming balances client choice with safety and security.
- Advocate for protection of the frail, disabled and elderly.

PARTNERSHIPS
The ILS specialist has a critical role in developing and maintaining partnerships with community resources.

To facilitate this partnering, the ILS specialist will:

- Advocate for programs to address the needs of ILS clients.
- Emphasize client choice and quality outcomes.
- Encourage access and availability of supportive services.

Work cooperatively with other agencies to ensure effective coordination of services.

Principles
Principles of effective partnerships include, but are not limited to:

- Exploring alternatives which are specific and unique to each client's circumstances - respect client choice.
- Monitoring to ensure clients/families are well informed.
- Encouraging increased supports for caregivers, where applicable.

PROGRAM GOALS
Independent living services are directed toward the following goals:

- To encourage and support the client's right and responsibility to make informed choices.
- To ensure the necessary supports are offered to assist client to live independently and with dignity.
- To recognize and encourage the client's natural support system.
- To ensure flexibility in service planning, respecting the client's to determine what services are necessary.
- To provide the necessary tools to enable client self-advocacy.

PROGRAM OUTCOMES
Program goal attainment will be measured by:

- **Client:** client will be referred to appropriate programs/ resources. The status of referrals will be closely monitored.
- **Client Safety:** each ILS client will be safely maintained in his/her own home.
- **Client Service Supports:** as a client's functionality declines, progressively increased service supports will be offered to enable living in the least restrictive setting.
- **Client Satisfaction:** all clients will express satisfaction with quality of life and services received through the Independent Living Services Program.

SERVICE DELIVERY METHODS
Independent living services are primarily delivered by the case management methodology. Services to non-Medicaid individuals are delivered by the supportive services methodology. See ASM 312 for methodology descriptions. **See Adult Services Glossary (ASG) for definitions.**

SERVICE DELIVERY METHOD
Independent living services are delivered by the case Management or supportive services methodologies. See ASM 312, service delivery methodology for further information.

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 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.

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. 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:

MDCH
Attn: Long Term Care, Systems Development Section
Capitol Commons, 6th Floor
Lansing, MI 48909

SERVICE PLAN

A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment.

The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy

Service planning is person-centered and strength-based.

Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service. Participants in the plan should involve not only the client, but also family, significant others, and the caregiver, if applicable. Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services, and
- Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

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).

Good Practices
Service plan development practices will include the use of the following skills:

- **Listen actively** to the client.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for **congruency** between case assessment and service plan.
- Provide the necessary supports to **assist** clients **in applying for resources**.

- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.
- **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

ELIGIBILITY FOR HOME HELP SERVICES
Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid(MA)
Verify the client's Medicaid/Medical aid status.

The client may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**
- MA deductible obligation has been met.

The client must have a scope of coverage of:

- 1F or 2F, **or**
- 1D or 1K (Freedom to Work), **or**
- 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rate by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

Medicaid Personal Care Option
Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and the ES.

Conditions of eligibility:

- The client meets all MA eligibility factors except income.
- An ILS services case is active on CIMS (program 9).
- The client is eligible for personal care services.
- The cost of personal care services is **more** than the MA excess income amount.
- The client agrees to pay the MA excess income amount to the home help provider.

Inform the ES of the amount of personal care services (HHS care cost) **and** the amount of personal care required but not approved for HHS payment, i.e., monthly payment does not meet total care needs.

If **all** the above conditions have been met, the client has met MA deductible requirements. The ES will send written notification of the MA effective date and the MA excess income amount.

Upon receipt of the ES notification, enter the client's deductible amount in the **"Resources"** tab of the **"Basic Customer"** module in **ASCAP**.

Note: Use the Services Approval Notice (DHS-1210) to notify the client of HHS approval when MA eligibility is met through this option. The notice must inform the client that the HHS payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA excess income amount (deductible) each month.

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

Notify the ES in writing of any changes in the client's personal care needs. The ES will send written notification of any changes in the monthly MA excess income amount.

MA eligibility under this option **cannot** continue **if:**

- The client no longer needs personal care; **or**
- The cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Program Eligibility Manual (PEM) 545, Exhibit III, regarding the Medicaid Personal Care Option.

Necessity For Service
The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client 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.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional 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 client and/or medical professional.

If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.

Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.

Adult Services Manual, September 1, 2008.

The Adult Services Manual addresses the fact that the Adult Services Worker must have verification of medical need in order to authorize Home Help Services. In this case the Department's worker looked at the DHS 54 that was returned to the Department and determined it did not authorize a medical need for services. In looking at the same document, this ALJ has determined reasonable minds can differ in that determination. Both the yes and no indications have been selected in one way or another. The form is signed and dated by a doctor and his Medicaid provider ID number is present on the form. The worker did not believe the form certified a medical need, thus sent a negative action notice right away without further investigation or action. Her testimony establishes she did not telephone the doctor's office prior to sending the negative action notice or the client. The mission statement, best practices and principals set forth in the manual do not support such an action when faced with an ambiguous document. The worker's action is not supported in the Policy manual precisely because she is to be an advocate on behalf of the client and it is not clear the doctor intends to state the Appellant in this instance, has no medical need. The form has several personal care activities circled and the "no" box is checked. However, the instrumental activities of daily living such as housework, meal preparation, laundry and housework is circled altogether, along with the "yes" indication. This is a sufficient reason for the worker to attempt to learn more before making an eligibility determination. At the very least, she was obligated to communicate with the client what the problem is and provide an opportunity to obtain a second form. The worker's uncontested testimony is that she had not met the Appellant prior to the hearing. She had not telephoned the doctor's office prior to making the eligibility determination and that she assumed the client had falsified the form. There was no evidence presented she sought to have a second form completed or sought any type of clarification. The policy does not support her determination.

The Appellant testified that he is legally blind due to diabetic retinopathy and has had his left lower leg amputated. He walks with assistance of a cane. He resides with his [redacted] mother and needs assistance in the house performing some Instrumental Activities of Daily Living. He was found credible by this ALJ. He further testified he did not complete the form at issue. He left it the clinic where he treats, along with the return envelope provided him by the DHS office. He said the clinic has doctors rotate in and out every three months.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

> The Department's decision is REVERSED. The Department is to send a second DHS 54 medical needs form to the Appellant's treating physician's office for completion, along with a return envelope. If the form is returned with ambiguities again, the worker is to have contact with the office to clarify what the doctor is

attempting to communicate with respect to the Appellant's medical needs PRIOR to making an eligibility determination.

Jennfier Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/4/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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.