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. 2009-35005 HHS
Case No. [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]. [redacted] represented himself at hearing.

[redacted], represented the Department. [redacted] was present as a Department witness. [redacted], was present as a Department witness.

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 program.

2. The Appellant resides in his own apartment. He is a spastic quadriplegic with very limited movement in his extremities, per DHS 54 dated 5/05 and 5/03. He is electric wheelchair dependent.

3. The Appellant had been approved for payment assistance through the Home Help Services program. He was receiving assistance with all

activities of daily living and instrumental activities of daily living except eating, grooming and medication.

4. The Appellant's case was due for a review in [redacted]. A Department worker sent his doctor a DHS 54-A medical needs form.

5. The DHS 54-A that was returned was vastly different from other, previously returned medical needs forms for the Appellant. The newly completed form indicated he is a paraplegic and required assistance with meal preparation, shopping, errands, laundry and housework only.

6. The Department's worker never made a home call after receipt of the DHS 54-A medical needs form in [redacted]. (testimony of Department worker)

7. The worker implemented reductions in payment assistance based upon the information read from the medical needs form received in [redacted]. (testimony of Department worker)

8. The worker reduced the payment assistance authorized from over [redacted] per month to [redacted] per month. (uncontested)

9. The worker sent what purported to be an Advance Negative Action Notice on [redacted] effecting a drastic reduction in payment with an effective date of [redacted].

10. The Appellant did not receive a comprehensive assessment at review or prior to the worker's determination that reductions were warranted in his case.

11. The Appellant requested a formal, administrative hearing [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. The Adult Services Manual describes the program goals and policies implemented by the Department:

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.

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.

PERSON CENTERED 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 right 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.
>
> **Adult Services Manual 361 June 1, 2007.**

The Adult Services Manual sets forth program procedures in manual item 363, in pertinent part below:

> **Service Plan Development**
> Address the following factors in the development of the service plan:
>
> **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**.
>
> **REVIEWS**
> ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.
>
> **Six Month Review**
> Requirements for the review contact must include:
> - A review of the current comprehensive assessment and service plan.
> - A reevaluation of the client's Medicaid eligibility, if home help services are being paid.

- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

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.

Payment for Medical Exams

The Medicaid card is to be used to pay for medical professional charges for examinations or tests to certify the client's need for services and for completing the DHS-54A for MA recipients.

Use the Examination Authorization/Invoice for Services (DHS-93) to pay for professional charges for non-MA clients. Payment is limited to the medical procedures and tests necessary to certify the client's need for home help services. See SRM 234, Diagnostic Fee Schedule.

Medical Review Team (MRT)
If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT evaluation is needed.

The local office designee will forward the packet to the regional Disability Determination Services (DDS) MRT.

The MRT will make a determination and return the forms. See L-letter 00-130, June 20, 2000.

The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.

Expanded Home Help Services (EHHS)
EHHS may be authorized if **all** of the following criteria are met:

- The client is eligible for HHS.
- The client has functional limitations so severe that the care cost cannot be met safely within the monthly maximum payment.
- The local office director/supervisory designee has approved the payment (EHHS $550-$1299.99) **or** the Department of Community Health (DCH) has approved the payment (EHHS $1300 or over).

All EHHS requests for approval must contain:

- Medical documentation of need, e.g., DHS-54A, **and**

- An updated DHS-324 **and** written plan of care which indicates:
  - How EHHS will meet the client's care needs **and**
  - How the payment amount was determined.

Note: See adult services home page for Expanded Home Help Services Procedure Guideline under Training Materials/Job Aids, developed by the Department of Community Health.

Adult Services Manual item 363 September 1, 2008

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: *****

The Appellant may be eligible for Expanded Home Help Services. Adult Services Manual (ASM 363) addresses expanded home help:

Expanded Home Help Services (EHHS)

EHHS may be authorized if **all** of the following criteria are met:

- The customer is eligible for HHS.

- The customer has functional limitations so severe that the care cost cannot be met safely within the monthly maximum payment.

- The local office director/supervisory designee has approved the payment (EHHS $550 - $1299) **or** the Department of Community Health (DCH) has approved the payment (EHHS $1300 or over).

All EHHS requests for approval must contain:

- Medical documentation of need, e.g., FIA-54A, **and**

- An updated FIA-324 **and** written plan of care which indicates:

    - How EHHS will meet the customer's care needs **and**
    - How the payment amount was determined.

Note: See Adult Services Home Page for Expanded Home Help Services Procedure Guideline, developed by the Department of Community Health.

* * *

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*

Finally the Code of Federal Regulation Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

> **§ 431.211 Advance notice.**
> The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.
>
> **§ 431.213 Exceptions from advance notice.**
> The agency may mail a notice not later than the date of action if—
> (a) The agency has factual information confirming the death of a recipient;
> (b) The agency receives a clear written statement signed by a recipient that—

> (1) He no longer wishes services; or
> (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
> (c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
> (d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);
> (e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
> (f) A change in the level of medical care is prescribed by the recipient's physician;
> (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
> (h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i).

In this case it is uncontested the worker implemented reductions in the Appellant's case without conducting a comprehensive assessment. She acted on the information provided on the DHS 54-A medical needs form alone. She did not conduct a home call. She did not seek to reconcile the conflicting information on the new DHS 54 with the numerous older forms indicating the Appellant is a spastic quadriplegic with very limited movement in his extremities, that he may use a catheter and may have need for a bowel program, that he is in an electric wheelchair. She did not follow policy.

The policy establishes she is to utilize case management principals and advocate on behalf of the client. She is to conduct an in home, face to face assessment. She is to monitor the case for congruency. She failed to perform the most basic protective function, to send advance notice of the drastic negative action she was implementing. She sent a notice on [redacted], indicating a cut from over [redacted] per month was to be effective [redacted]. This is not advance notice. It is a retroactive cut to his benefit. None of the exceptions to the 10 day rule apply in this case. The worker sent the Notice in violation of the Code of Federal Regulations. Frankly, the blatant disregard for the safety, security and rights of the Appellant displayed by the worker in this case is alarming to say the least. Contrary to protecting this Appellant, as per Adult Services Manual policy, the worker placed the well being of the Appellant at risk by seeking to enact cuts retroactively, based upon what is at best described as a paucity of uncorroborated evidence. Years of case history evidence the Appellant is not a

paraplegic, rather, he is a spastic quadriplegic. The case record evidence is that he has high personal care needs and is dependent on the program to remain in the community. The Adult Services Policy Manual does not authorize her to enact the cuts in this manner. It was Department error to seek to enact the cuts without conducting a comprehensive assessment first and seeking to clarify the conflicting medical information pertaining to this individual. The differences in the DHS 54 A's submitted are glaring and material to what is appropriate for this individual. There is no reason in evidence for the worker to have failed to carry out her mandated obligation to perform individual case planning and seek to determine more information prior to enacting drastic cuts.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has improperly sought to reduce the Appellant's Home Help Service Payments.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department is hereby ordered to reinstate the Appellant's HHS payments to the amount authorized prior to the [redacted], Advance Negative Action Notice, if it has not already done so.

Furthermore, the Department is ordered to conduct an actual face to face comprehensive assessment and have contact with the Appellant's doctor's office to reconcile the conflicting medical information pertaining to his medical needs. If satisfactory information cannot be obtained from the doctor's office, the medical records are to be sent to the MRT for review, as per Adult Services Policy manual.

The Department is further ordered to refer the case to the Expanded Home Help Services section in Lansing if it appears as if the Appellant's needs cannot be met with the funds available without approval for Expanded Home Help Services.

_____

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

[redacted]
Docket No. 2009-35005 HHS
Decision and Order

cc: [redacted]

Date Mailed: 11/23/2009

***** 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.