STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-29304 HHS
[redacted]

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 on [redacted]. The Appellant appeared without representation. Appeals Review Officer, [redacted], represented the Department. [redacted], Adult Services Worker, testified on behalf of the Department. Adult Services Supervisor [redacted] was also present.

ISSUE

Did the Department properly terminate Appellant's Home Help Services (HHS) payments?

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 HHS program.

2. The Appellant is diagnosed with hypertension, hyperlipidemia, degenerative joint/disc disease in his lumbar spine, allergic rhinitis, and insomnia. (Exhibit 1, page 11)

3. The Appellant had been receiving payment assistance for the following Instrumental Activities of Daily Living (IADLs): housework, laundry, shopping, and meal preparation. (Exhibit 1, page 9)

4. An annual case review was scheduled with the chore provider for [redacted]. The Adult Services Worker, [redacted], went to the Appellant's home that day to complete a comprehensive assessment and case review. (Exhibit 1, pages 4-6)

5. The chore provider was not at the home, and the Appellant questioned [redacted] as to why the chore provider had to be present. (Exhibit 1, page 5)

6. [redacted] stated that she did not want to argue with the Appellant, so she left the home. (Testimony of [redacted])

7. [redacted] issued a Negative Action Notice on [redacted] with an effective date of [redacted] (Exhibit 1, page 4-6)

8. The Appellant requested a hearing on [redacted] (Exhibit 1, page 3)

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 health professional and may be provided by individuals or by private or public agencies.

DHS HHS staff is mandated to conduct regular reviews of HHS cases. The DHS policy related to assessment and reviews states, in pertinent part, as follows:

COMPREHENSIVE ASSESSMENT

> The Adult Services Comprehensive Assessment (FIA-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 redetermination**.
>
> • A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency record.
>
> • Follow specialized rules of confidentiality when ILS cases have companion APS cases.
>
> *Adult Services Manual (ASM 363 9-1-08), page 2 of 26*
> (Bold emphasis added by ALJ).

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.

* * *

Annual Redetermination

> Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

> Requirements:
> • A reevaluation of the client's Medicaid eligibility, if home help services are being paid. • A new medical needs (DHS-54A) certification, if home help services are being paid.
> **Note:** The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.
> • A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.
>
> *Adult Services Manual (ASM 363 9-1-08), page 6-7 of 24*

There is no dispute between the parties that the chore provider was not available for the annual review assessment scheduled on [redacted]. However, the Department improperly terminated the Appellant's HHS case on this basis.

First, it is unclear that DHS policy supports a termination based solely on the chore provider's failure to appear for an assessment. The Adult Services Manual states that HHS benefits may be terminated for any of the following reasons:

> **TERMINATION OF HHS PAYMENTS** Suspend and/or terminate payments for HHS in **any** of the following circumstances:
>
> • The client fails to meet any of the eligibility requirements.
> • The client no longer wishes to receive HHS.
> • The client's provider fails to meet qualification criteria.
>
> *Adult Services Manual (ASM 362 12-1-07), page 4 of 5.*

The Department referred to the first reason—failure to meet eligibility requirements—as its basis for termination in this case. More specifically, the Department asserts that because the chore provider failed to appear, and because the Appellant was uncooperative with the worker, an annual assessment could not be conducted, and termination was warranted.

The policy requires the following criteria to be met in order to be eligible for HHS:

ELIGIBILITY CRITERIA

*** * ***

Home Help Services (HHS)

Payment related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:

- The client must be eligible for Medicaid.

- Have a scope of coverage of:
  - 1F or 2F,
  - 1D or 1K, (Freedom to Work), **or**
  - 1T (Healthy Kids Expansion).

- The client must have a need for service, based on
  - Client choice, **and**
  - Comprehensive Assessment (DHS-324) indicating a functional limitation of level 3 or greater in an ADL or IADL.

- Medical Needs (DHS-54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:
  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

Adult Services Manual (ASM) 362, pages 1-2, 12-1-2007
(Exhibit 1, pages 18-19)

The policy does not explicitly support the Department's position that termination is warranted based solely on a chore provider's failure to appear for an annual assessment. While it is clear that an initial comprehensive assessment is required to determine eligibility, and that both six-month reviews and annual assessments are required to be completed, it is unclear that the chore provider must be present, in the home, given the vague "if applicable" language in the policy.

But even if policy did support termination for a chore provider's failure to appear at an assessment, it was not warranted in this case. This was the first scheduled assessment, and the Adult Services Worker made no attempts to reschedule the

assessment. Indeed, the worker sent out the Advance Notice on [redacted] - the same day as the failed assessment. While the worker testified that she did attempt to explain that the provider could call her at the office, the Appellant did not recall such a statement being made. And further attempts could have been made by the worker after she left the home.

Further, the termination in this case does not comport with the policy regarding the worker's duties to the beneficiary regarding assistance, advocacy, and case management, which provides as follows:

> **MISSION STATEMENT**
>
> Adult services seeks to maximize the independent functioning of adults and the independent control of adults over their own lives; to protect vulnerable adults from abuse, neglect, and exploitation; and to advocate for the aged and disabled.
>
> * * *
>
> **Program Goals**
>
> Assist adults and their families in selecting the most appropriate and least restrictive care and:
>
> • Assist adults to continue or resume living independently by arranging for in-home services, e.g., Home Help.
>
> • Assist adults and their families in locating and arranging for out-of homecare. For adults living independently, help arrange services to ensure basic well-being and safety--including medical, home help, and other social, educational or vocational services. For adults in out-of-home care, maximize independent functioning by arranging medical, mental health, social, educational or vocational services; facilitate movement to an independent living arrangement, if appropriate, or assist in maintaining the adult in out-of-home care. Provide immediate investigation and assessment of situations referred to the department when an adult is suspected of needing protection. For those found to be in need of protection, provide services to assist the adult in achieving a safe and stable status, including using legal intervention, where required, in the least intrusive or restrictive manner.
>
> *Adult Services Manual (ASM 311 1-1-08)*

Independent Living Services are offered as part of the Adult Services available to eligible beneficiaries. The policy manual sets forth specific eligibility criteria and Department responsibilities below.

> **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.

* * *

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.

* * *

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 omitted)

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.**

ASM 312, referenced above states:

SERVICE DELIVERY METHODOLOGY INTRODUCTION

There are three types of service methodologies available:

• Case management.

• Protective intervention.

• Supportive services.

Every open adult services case must have a services methodology indicator as per instructions in ASM 391.

Case Management Methodology
Case management is the primary service delivery method. All ongoing cases in which the client is receiving Medicaid or has an active Medicaid deductible case will be eligible for the case management services delivery method. Case management is an ongoing process which assists adults in need of home and community-based long-term care services to access needed medical, social, vocational, rehabilitative and other services.

Core Elements

- Comprehensive assessment to identify all of the client's strengths and limitations in the areas of physical, cognitive, social and emotional functioning as well as financial and environmental needs.

- Comprehensive individualized service plan to address the identified strengths and limitations of the client using the information obtained in the assessment.

- Mobilization and coordination of providers, family and community resources to implement the service plan by authorizing/arranging for needed services or advocating for the client to access needed government or community services.

- Ongoing monitoring of services to maintain regular contact with the client, informal caregivers and other service providers to evaluate whether the services are appropriate, of high quality, and are meeting the client's current needs.

- Regular assessment and follow-up as a formal review of the client's status to determine whether the person's situation and functioning have changed and to review the quality and appropriateness of services. Eligibility for case management services is limited to those clients who are currently receiving Medicaid.

Case Management Requirements
Assessment: Complete the DHS-324, Adult Services Comprehensive Assessment, and authorize any payments necessary.

Service Plan: The plan is generated by Adult Services Comprehensive Assessment Program (ASCAP) software from the issue areas identified in the assessment. Each module has a service plan component, with

identified issues generating strategy and goal screens. Workers are to enter data in those screens, with progress notes in the General Narrative.

Contacts: The case manager will make a face-to-face contact with each case management client, in the residence, **as often as needed**, but at least one time within a six calendar month period. The contacts may be on a flexible schedule as identified in the comprehensive assessment and service plan. The worker is to update ASCAP screens for any information that has changed. Progress notes may be added in the **General Narrative** section. Interim telephone contact with the client, caregiver, family members, etc. is recommended.

Note: Use the Comprehensive Assessment, Service Plan and most recent Contacts as a Guideline for determining frequency of face-to-face visits. Examples of cases that may need more frequent contacts (but not limited to) are listed below.

- High needs cases such as complex care and expanded home help services (EHHS) cases over $600 a month.

- Cases recently converted from adult protective services (APS) to independent living services (ILS) or adult community placement (ACP).

- Cases of adult children living with parents (caregivers) whose health and functional ability is deteriorating.

- Any situations where there is concern about the quality of care or the reliability of the provider.

- Clients whose health is rapidly deteriorating.

- Clients whose health is improving and a reduction in Home Help may be appropriate.

- Clients with recent and/or frequent hospitalizations.

- Clients in adult foster care or homes for the aged (HA) in need of frequent relocation.

- ILS clients moving to an AFC or HA (transition adjustment period).

> **Mobilization/Coordination of Services**
> **The worker acts as an advocate for the adult.**
> Through negotiation and referrals, the worker links the client to various providers of care. The worker may arrange direct services such as Home Help, and personal care/supplemental payment in Adult Foster Care/Home for the Aged (AFC/HA), but may not restrict the adult's choice of a **qualified** service provider. In many cases it will be necessary to mobilize one or more sets of resources to make adequate services available.
>
> **Monitoring and Review/Redetermination**
> Ongoing follow-up and monitoring of the client's situation by the case manager is necessary and consistent with professional casework practice. This regular review will assure that services are being delivered as specified in the service plan and that they are adequate for the identified needs of the client. It also provides the opportunity to adjust the plan of care if needed, to change provider arrangements, to assure quality of care through personal contact and to provide support and counseling. Cases must be reviewed every six months through a face-to-face contact with the client in the client's residence. The worker must examine all ASCAP screens at review, updating information as needed. The worker is to follow the same procedures for annual redeterminations as listed above for reviews. In addition, Medicaid eligibility is to be reconfirmed and continued need for services established. Expanded Home Help cases must be reapproved locally at this time by the local office director or supervisory designee.
>
> *Adult Services Manual (ASM 312 6-1-07)*(protective services methodology manual items omitted)

Termination of services is a serious action that must only be undertaken with care, case planning, and only after the worker ascertains how the client's needs will continue to be met. Here, no such considerations were made. Therefore, termination in this case was improper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department's termination of the Appellant's HHS benefits was improper.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department must reschedule the annual assessment at a mutually convenient time, and, if needed, allow the provider to meet with the worker at the DHS office.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/2/2010

***** 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.