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

Docket No. 2010-35113 HHS
Case No. [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented herself at hearing. Her provider was present.

[redacted] Appeals and Review Officer, represented the Department of Community Health. [redacted], Adult Services Worker (ASW), appeared as a witness on behalf of the Department. [redacted], Adult Services Worker, was also present.

ISSUE I

Did the Department properly reduce Home Help Services (HHS) payments to the Appellant?

ISSUE II

Did the Department properly refuse the request for re-assessment following the Appellant's release from the hospital?

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 is [redacted] She lives alone in a trailer. She is diagnosed with arthritis, dementia, has history of stroke and a recent hospitalization for pneumonia. She is incontinent.

3. The Appellant has a cane, however, uses the furniture in her home to steady herself when she walks.

4. The Appellant is receiving payment assistance for the following Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): bathing, grooming, housework, laundry, shopping and meal preparation.

5. The Appellant had an annual case review in [redacted]. The Department's worker went to her residence for the purpose of completing a comprehensive assessment and case review.

6. The Appellant's provider was asked to be present, however, was sick on the date of review, thus absent.

7. The worker conducted a comprehensive assessment in [redacted]. She asked the Appellant how often her provider came and what she did.

8. The worker was informed by the Appellant that her provider bathed her two (2) times per week, prepared meals two (2) days per week and performed the housework, laundry and assisted with shopping.

9. The worker spoke on the telephone with the Appellant's provider. The provider informed her she went to the Appellant's home four (4)-five (5) days per week, reserving one day for errands completed on behalf of the Appellant.

10. The worker reduced the payments for bathing, grooming and meal preparation following the comprehensive assessment and reportedly based upon what the Appellant told her during the same.

11. The worker was asked to perform a new comprehensive assessment following notification of department reductions. She informed the provider she would not.

12. The Appellant was hospitalized for 5 days, for pneumonia, in [redacted].

13. The worker was asked to perform a new assessment following the Appellant's release from the hospital. She telephoned the public health nurse and determined she would not conduct another new assessment.

14. The Appellant was released from the hospital with a reported increase in fatigue/weakness and in home physical therapy.

15. The worker's Negative Action Notice was sent [redacted], with an effective date of [redacted].

16. The Appellant contests the reductions and lack of re-assessment following release from the hospital.

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.

Adult Services are part of the services authorized in the State of Michigan for eligible Medicaid beneficiaries. Independent Living Services (ILS) are offered as part of the State Adult Services Program. The ILS program is administered by Department of Human Services on behalf of the Department of Community Health. The Adult Services policy manual contains the policy statements and program eligibility criteria. Its pertinent portions are set forth below.

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.

Principles

In carrying out this mission, certain operating principles are to be considered.

These are:

- Adults have a right to make their own decisions. This includes:
  - Decisions as to whether they want service, what services or how much and from whom,
  - Decisions as to where they live, and
  - Decisions to determine a plan of service.
- Services must recognize the role of the family. Family involvement should be supported by:
  - Seeking out the family,
  - Involving them in service planning, and
  - Directing services and resources toward the family in their role as caregiver. If the interest of the family and the adult compete, the adult's interest is primary.

> • Services should be the least intrusive, least disruptive and least restrictive.
> • Services should be part of a coordinated network of community based services, using all appropriate existing community services and identifying the need for developing additional services.
> • In providing services to adults, the full range of social work skills focused on person centered planning should be used to inform clients of services and alternatives available and the impact of decisions to assure informed choices. Workers should consider strength based solution focused techniques.
>
> **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.
>
> ASM 311, 1-1-2008

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.

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.

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.

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 services.

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 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.
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> (protective services methodology manual items omitted)
>
> ASM 312, 6-1-2007

Program requirements are set forth in Adult Services Manual item 362, below:

> **GENERAL SERVICES REQUIREMENTS** The client must sign an Adult Services Application (DHS-390) to receive ILS. An authorized representative or other person acting for the client may sign the DHS-390 if the client:
>
> • Is incapacitated, **or**
>
> • Has been determined incompetent, **or**
>
> • Has an emergency. A client unable to write may sign with an “X”, witnessed by one other person (e.g., relative or department staff). Adult services workers must not sign the services application (DHS-390) for the client. Eligibility must be determined within 45 days of the signature date on the DHS-390.
>
> **Note:** ASSIST (Automated Social Services Information and Support) requires a disposition within 30 days of the registered request. See ASSIST User Manual (AUM) 150-7/8. The DHS-390 is valid indefinitely unless the case is closed for more than 90 days.

ELIGIBILITY CRITERIA

Independent Living Services The following **nonpayment** related independent living services are available to any person upon request **regardless** of income or resources:

- Counseling.
- Education and training.
- Employment.
- Family planning.
- Health related.
- Homemaking.
- Housing.
- Information and referral.
- Money management.
- Protection (For adults in need of a conservator or a guardian, but who are not in any immediate need for protective service intervention.)

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.

Expanded Home Help Services (EHHS)

EHHS eligibility exists if **all** HHS eligibility criteria are met **and** the assessment indicates the client's needs are so severe that the cost of care cannot be met within the HHS monthly maximum payment.

Home Help Services (HHS) in the Workplace Home help services may now be provided for the specific purpose of enabling the client to be employed.

- The current assessment process for personal care needs remains unchanged. A separate assessment for the workplace is not required.
- The hours approved may be used either in the home or the workplace.

Additional hours are not available as a result of employment.

- The client determines where services are to be provided, whether in the home or the workplace.

Service Animal

Eligibility for service animal maintenance payments exists if the client:

- Is eligible for HHS, **and**
- Has a certified need for a service animal.

COMPREHENSIVE ASSESSMENT

If the client appears eligible for independent living services, conduct a face-to face interview with the client in their home to assess the personal care needs. Complete the comprehensive assessment (DHS-324) which is generated from the Adult Services Comprehensive Assessment Program (ASCAP).

SERVICE PLAN

Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the assessed needs of the client. The ILS service plan is developed whenever an issue is identified in the comprehensive assessment.

CONTACTS

The worker must, at a minimum, have a face to face interview with the client **and** care provider, prior to case opening, then every six months, in the client's home, at review and redetermination.

NOTIFICATION OF ELIGIBILITY DETERMINATION

Provide any person who applies for independent living services with a written notice of approval, denial or withdrawal.

Services Approval Notice (DHS-1210)

If independent living services are approved, complete and send a DHS-1210 indicating what services will be provided. If home help services will be authorized, note the amount and the payment effective date.

Advance Negative Action Notice (DHS-1212)
If independent living services are denied or withdrawn, or if payment is suspended or reduced, the adult services worker must notify the client of the negative action.The Advance Negative Action Notice (DHS-1212) is used and automatically generated on ASCAP when the following reasons are selected:

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

Adequate Negative Action Notice (DHS 1212A)
The Adequate Negative Action Notice (DHS-1212A) is used and generated on ASCAP when ILS cases have been denied or withdrawn. The DHS-1212 and DHS-1212A informs the client of the right to request a hearing and explains the procedures for requesting a hearing The Request for Hearing form (DCH-0092) is also generated when either the DHS-1212 or DHS-1212A are printed and must be mailed along with the negative action notice. The adult services worker must sign the bottom of the second page before forwarding it to the client.

REVIEW
Update the comprehensive assessment and the service plan every six months. Review the adequacy of the service plan to assure it meets the client's current needs. Review eligibility for independent living services every 12 months, or sooner if the client's condition or circumstances warrant.

The annual review requires:

- MA eligibility verification, if relevant.
- Comprehensive assessment.
- Service plan.
- Renewal of the medical needs (DHS-54A).

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 must have a DHS-54A completed at the initial opening and then annually thereafter.

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.

When HHS are terminated or reduced for any reason, send a DHS-1212 to the client advising of the negative action and explaining the reason. Continue the payment during the negative action period. Following the negative action period, complete a payment authorization on ASCAP to terminate payments. If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action. See Program Administrative Manual (PAM) 600 regarding interim benefits pending hearings and Services Requirements Manual (SRM) 181, Recoupment regarding following upheld hearing decisions.

REINSTATEMENT OF HHS PAYMENTS

When HHS payments have been terminated and subsequently reopened within 90 days, they may be reinstated without completing a new DHS-390 if the client meets eligibility criteria.

JOINT POLICY DEVELOPMENT

The Adult Services Manual (ASM) policy has been developed jointly by the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS).

ASM 362, 12-1-2007

Manual Item 363 addresses what a comprehensive assessment consists of, as well as other program procedures.

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.

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 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).

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.

Documentation
Case documentation for all reviews should include:
• Update the **"Disposition"** module in ASCAP.
• Generate the CIMS Services Transaction (DHS-5S) from **forms** in **ASCAP**.
• Review of **all** ASCAP modules **and** update information as needed.
• Enter a brief statement of the nature of the contact and who was present in **Contact Details** module of ASCAP.
• Record expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
• Record summary of progress in service plan by clicking on **Insert New Progress Statement in General Narrative** button, found in any of the **Service Plan** tabs. **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.

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.

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. **Service Animal** Payment for maintenance costs of a service animal may be authorized if **all** of the following conditions are met:

- The client is eligible for HHS.
- The client is certified as disabled due to a specific condition such as arthritis, blindness,

cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury.
• The service animal is certified as professionally trained by a recognized agency to meet specific needs of the client.
• The HHS plan documents that the service animal will be used primarily to meet specific client personal care needs.

Service animal maintenance may be authorized for a client in an alternative care setting (AFC or HA). Authorize payment for maintenance costs of a service animal if the client meets **all** eligibility criteria.

COORDINATION OF HHS WITH OTHER SERVICES
Coordinate available home care services with HHS in developing a services plan to address the full range of client needs. Do **not** authorize HHS if another resource is providing the same service at the same time.

Supported Independent Living Programs (SIP)
Clients in supported independent living program homes (SIP) may be eligible for HHS payments. See L-Letter 97-278.

Services not Covered by Home Help Services
Do **not** authorize HHS payment for the following:

- Supervising, monitoring, reminding, guiding or encouraging (functional assessment rank 2);
- Services provided for the benefit of others;
- Services for which a responsible relative is able and available to provide;
- Services provided free of charge;
- Services provided by another resource at the same time;
- Transportation - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.
- Money management, e.g., power of attorney, representative payee;
- Medical services;
- Home delivered meals;
- Adult day care.

> **Note:** If it appears the client's primary need is for adult foster care (AFC) or foster care is being provided without a license, the case should be referred to the local AFC licensing consultant.
>
> ASM 363, 9-1-2008

The evidence of record establishes the assessment conducted in February resulted in reductions in payment assistance in only a few areas, bathing, grooming and meal preparation. There is no dispute the Appellant was being assisted with bathing two (2) days per week. The time allowed was contested as insufficient, not the number of days allowed. The Department's evidence was that the reasonable time and task for bathing determined the 18 minute intervals, thus that is what was paid. Policy allows the worker to adjust the time up or down, depending on the client's needs. All that is needed is some explanation or documentation to justify an upward or downward adjustment to time. RTS stands for reasonable time and task. It is not set in stone. Here, the only evidence about how time for bathing was determined from the Department is that the reasonable time and task set it. There was no evidence presented the worker made direct observations of the client's abilities and determined RTS was adequate. Nor was there evidence the worker considered statements from the Appellant in assisting the time for this task. The evidence was merely that it is computer generated. This does not address this client's specific needs. The uncontested credible evidence is that the client is slow, presumably due to her age and medical status. The worker does have an obligation to address the client's specific circumstances and needs. From the Adult Services Manual:

> 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.** (emphasis added by ALJ)

There is a good basis for reducing the number of day to two (2) for bathing, however, the time allowed is insufficient in this instance. Policy does not require the worker to leave the time for a particular ADL at the level set by the computer program, thus the worker should have addressed the need accordingly.

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The evidence regarding grooming was not sufficiently contested by the client to reverse the Department's determination that 10 minutes two (2) days per week is sufficient to address the client's needs. While there was evidence the provider puts lotion on the client's feet, the time authorized appears sufficient to complete this task.

The evidence regarding meal preparation is that the client is able to get simple meals for herself, has two (2) meals a week brought in and has some limited meal preparation

from her provider. While the client is ranked a four (4), nearly maximal assistance, the payment authorization is only for two (2) days. While this ALJ harbors concerns the care plan does not addresses the client's needs adequately concerning meal preparation, little evidence was presented by the Appellant concerning this. This ALJ has insufficient evidence to reverse the Department's determination regarding meal preparation at the [redacted], assessment, however, it is an area that required a new assessment following release from the hospital, which is addressed below.

In this case, the Department's worker conducted a comprehensive assessment at the scheduled review. The provider and client were dissatisfied with it and sought a new assessment. The dissatisfaction expressed alone is an insufficient basis to conduct a new assessment, however, circumstances did change shortly thereafter which did warrant a new assessment. The elderly client was hospitalized for five (5) days with pneumonia. The worker was apprised of the hospitalization and reason therefore. She was further apprised the client had increased fatigue/weakness and was receiving in home physical therapy. Furthermore, the client was unsteady and dizzy. Additionally, there was a renewed request for a new assessment following release from the hospital. The recent release from the hospital of such an elderly client is a sufficient basis to conduct a new assessment. Policy states the assessments are to take place as often as necessary and at least every six (6) months. Hospitalization is even cited in policy as a reason a worker may need to conduct a new assessment. The six (6) month time frame is not the minimum amount of time a client has to wait for a new assessment, it is the maximum. The telephone call the worker placed to the nurse is an insufficient substitute for a new assessment, as the testimony at hearing revealed.

At hearing, the client testified credibly she requires assistance with medication set up. If the worker had conducted a new assessment upon her release from the hospital, she would have had opportunity to learn of this new development. Furthermore, the client credibly testified she required assistance dressing because she needs help getting her socks on. Again, if the worker had conducted a new, adequate assessment, she would have learned of the client's needs upon release from the hospital. The worker would have learned of the client's increased needs had she conducted a new assessment when it was actually needed rather than repeatedly inform the provider and client to wait until August. Given the client's known increase in weakness and fatigue, it is possible she is not able to get the meals for herself that she was previously able to prior to a hospitalization. Given the determination that the client required assistance with meal preparation and was ranked four (4) out of five (5), two (2) days a week for assistance is quite minimal. Following a hospitalization, it would be reasonable and likely to require more help than two (2) days per week. Finally, the client's mobility and continence needs may also be at issue following release from the hospital. The worker was informed she is unsteady, dizzy and more fatigued. The worker already knew she is incontinent and using furniture to steady herself. It was quite possible the client needed assistance getting to and from the bathroom or on and off a toilet given her unsteady gait and incontinence. This too should have been addressed at a new assessment following release from the hospital.

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The Adult Services policy does require the worker to act as an advocate for the client, protect the client and to provide case management services. The best practices, principals, and requirements of case management are set forth above. At a minimum, it would require a new assessment for an elderly client living alone who was just released from the hospital for pneumonia. The testimony at hearing revealed the worker would have learned of the client's new need for services and possibly of a need for increase in some areas. Although the assessment conducted in [redacted], was largely adequate, it was inadequate for bathing. A release from the hospital is change in circumstances that warrants an in person contact, thus the Department's determinations cannot be upheld in their entirety**.**

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DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly reduced assistance in the areas of grooming and meal preparation up to the date of release from the hospital.

It is further found the Department improperly denied a request for a new comprehensive assessment. Finally, it is further found the Department improperly reduced assistance for bathing.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED in part and REVERSED in part.

The Department payment assistance for bathing must reflect the increased need for time for the two (2) days bathing is authorized. Furthermore, because the Department improperly denied the request for a new assessment following release from the hospital, the Department must re-assess the Appellant's needs at the earliest opportunity.

_____

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

[redacted]
Docket No. 2010-35113 HHS
Decision and Order

cc: [redacted]

Date Mailed: 7/29/2010

***** 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.