STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-019403 HHS
Case No. [redacted]

Appellant.
_____/

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 Appellant's request for a hearing.

After due notice, a telephone was held on [redacted]. Appellant appeared and testified. Appellant's provider, [redacted], appeared and testified. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], Adult Services Worker and [redacted], Departmental Analyst, appeared as witnesses for the Department.

State's Exhibit A, pages 1-16 were admitted on the record as evidence.

ISSUE

Did the Department properly determine that Appellant's Provider was no longer eligible to be paid to perform Appellant's Home Help Services (HHS)?

FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary.

2. Appellant is approved for HHS.

3. Appellant's son has been providing HHS services for Appellant as an authorized provider.

4. On [redacted], the Department sent Appellant an Advance Negative Action Notice informing him that he would need to identify a new HHS provider because the current HHS provider was found to have a Mandatory Exclusion conviction and would no longer be eligible for payment effective [redacted].

5. On [redacted], Appellant filed a request for hearing to contest the Department's negative action.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

Adult Services Manual (ASM) 101, 12-1-13, addresses HHS payments:

> **Payment Services Home Help**
>
> Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.
>
> Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.
>
> *Adult Services Manual (ASM) 101, 12-1-2013, Page 1of 4.*

Adult Services Manual (ASM) 105, 12-1-13, addresses HHS eligibility requirements:

> **Requirements**
>
> Home help eligibility requirements include all of the following:
>
> - Medicaid eligibility.
> - Certification of medical need.
> - Need for service, based on a complete comprehensive assessment (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
> - Appropriate Level of Care (LOC) status.

***

Necessity For Service

The adult services specialist is responsible for determining the necessity and level of need for home help services based on:

- Client choice.
- A completed DHS-324, Adult Services Comprehensive Assessment. An individual must be assessed with at least one activity of daily living (ADL) in order to be eligible to receive home help services.

  Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Adult Services Manual (ASM) 105,
12-1-13, Pages 1-3 of 3

Adult Services Manual (ASM 120, 12-1-2013), pages 1-4 of 5 addresses the adult services comprehensive assessment:

INTRODUCTION

The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining need for services. The comprehensive assessment must be completed on **all open independent living services cases**. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the client in his/her place of residence.
- The assessment may also include an interview with the individual who will be providing home help services.
- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual redetermination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
    - Use the DHS-27, Authorization to Release Information, when requesting client information from another agency.
    - Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation; see RFF 1555. The form is primarily used for APS cases.
- Follow rules of confidentiality when home help cases have companion APS cases, see SRM 131 Confidentiality.

***

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating.

- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking Medication.
- Meal Preparation and cleanup.
- Shopping.
- Laundry.
- Light Housework.

Functional Scale

ADLs and IADLs 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.

Home help payments may only be authorized for needs assessed at the 3 level ranking or greater.

An individual must be assessed with at least one activity of daily living in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADLs if the assessment determined a need at a level 3 or greater.

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for activities of daily living and instrumental activities of daily living.

***

Time and Task

The specialist will allocate time for each task assessed a rank of 3 or higher, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a **guide**. The RTS can be found in ASCAP under the Payment module, Time and Task screen. When hours exceed the RTS rationale **must** be provided.

An assessment of need, at a ranking of 3 or higher, does not automatically guarantee the maximum allotted time allowed by the reasonable time schedule (RTS). **The specialist must assess each task according to the actual time required for its completion.**

Example: A client needs assistance with cutting up food. The specialist would only pay for the time required to cut the food and not the full amount of time allotted under the RTS for eating.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all instrumental activities of daily living 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

Proration of IADLs

If the client does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for

> each task. Assessed hours for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as home help services are **only** for the benefit of the client.
>
> **Note:** This does not include situations where others live in adjoined apartments/flats or in a separate home on shared property and there is no shared, common living area.
>
> In shared living arrangements, where it can be **clearly** documented that IADLs for the eligible client are completed separately from others in the home, hours for IADLs do not need to be prorated.
>
> **Example:** Client has special dietary needs and meals are prepared separately; client is incontinent of bowel and/or bladder and laundry is completed separately; client's shopping is completed separately due to special dietary needs and food is purchased from specialty stores; etc.
>
> *Adult Services Manual (ASM) 120, 12-1-2013, Pages 1-5 of 5*

All Medicaid providers are required to enter into Medicaid Provider agreements.

> (4) A provider shall enter into an agreement of enrollment specified by the director.
>
> (M.C.L. § 400. 111b(4))

The Social Welfare Act, M.C.L. § 400.1 *et seq*., provides that as a condition of participation in the Medicaid program a provider must meet all the requirements listed in M.C.L. § 400.111b.

> (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).
>
> (M.C.L. § 400.111b(1))

The Department Director has authority to establish policies related to enrolled Medicaid Providers, including that the provision of services and reimbursement of those services be for medically necessary services. M.C.L. § 400.111a.

The mere fact that a provider submits a claim or cost report for services rendered does not establish entitlement. M.C.L. § 400.111b(10) provides:

> …Submission of a claim or claims rendered under the [Medicaid] program does not establish in the provider a right to receive payment from the program.

If the Department disputes the amount of payments the provider is entitled to an administrative hearing pursuant to M.C.L. § 400.111c. The burden to prove entitlement to Medicaid reimbursement is on the Appellant. *Prechel v. MDSS*, 186 Mich. App. 547, 549; 465 N.W.2d 337 (1990).

The Michigan Department of Community Health (MDCH) utilizes the authority extended to the State of Michigan 42 USC 1396t (k)(4) to meet the requirements under 42 CFR 441.570 to assure that "necessary safeguards have been taken to protect the health and welfare of enrollees." Bulletin number MSA 14-40 extends the Medicaid provider criminal history screening and enrollment requirements to individuals who offer personal care services through the Medicaid Home Help program. Additionally, it includes a list of excludable convictions as outlined in bulletin MSA 14-31 to include permissive exclusions. The screening requirements are to apply to all providers of Medicaid personal care services. The requirements apply to both individual providers and to those providing services as an employee of the provider agency.

MSA Bulletin 14-40 states in pertinent part:

Personal care services include services provided to a Medicaid beneficiary to assist the beneficiary with completing their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) while the beneficiary is in a home community-based setting. ADLs include eating, bathing, dressing, toileting transferring, mobility, walking, and personal hygiene. IADLs include financial management, shopping, telephone use, transportation, housekeeping, meal preparation and managing medications.

Beginning October 2, 2014, all new provider applicants must fully meet the provisions of Home Help Provider Bulletin MSA 14-40: Excludable Convictions for Medicaid Help Program Personal Here Service Providers before Being Enrolled to Provide Services. Providers Must Be Properly Enrolled Prior to being authorized, approved or reimbursed to provide personal care services for the Medicaid Home Help program. In Addition, all currently enrolled providers must be fully compliant with the provisions of the policy by March 31, 2015.

Excludable convictions fall into two categories. Mandatory exclusion as discussed in bulletin MSA 14 – 31 are those set forth in the Social Security act 42 USC 1320a-7[a]. Permissive exclusions are allowed under part(b) of that section.

Mandatory exclusions are:

Convictions associated with program related fraud and patient of use, healthcare fraud, and felony controlled substance crimes. These exclusions are mandated and defined under 42 USC 1320a-7 and articulated in Bulletin MSA 14 – 31.

In the instant case, Appellant protests the cancellation of his provider's eligibility to be paid to provide HHS services. Appellant testified that his son has provided satisfactory HHS services for several years. Though he had some problems in his past, he has cleaned himself up and is a trustworthy provider. Appellant is afraid to hire a stranger because there are so many cases of abuse.

Appellant's provider conceded on the record that he does have a substance abuse conviction which occurred when he was about [redacted] years old. He is nearly [redacted] years old and has been providing services for several years.

Based on the evidence presented, the Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with Department policy when it determined that Appellant's provider had a Mandatory Exclusion and could no longer be paid to provide Home Help Services to Appellant effective [redacted]. Convictions associated with program related fraud and patient of use, healthcare fraud, and felony controlled substance crimes are mandatory exclusions. These exclusions are mandated and defined under 42 USC 1320a-7 and articulated in Bulletin MSA 14 – 31. The department's decision must be upheld under the circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, based on the available information, the Department properly determined that Appellant's provider could no longer be qualified to be paid to provide Appellant's HHS because he had a mandatory exclusion in the form of a felony controlled substance conviction.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

[redacted]
Docket No. 15-019403 HHS
Decision and Order

LYL/[redacted]

Date Signed: December 22, 2015

Date Mailed: December 23, 2015

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant March 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.