

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

P.O. Box 30763, Lansing, MI 48909  
(877) 833-0870; Fax: (517) 373-4147

**IN THE MATTER OF:**

██████████,

Appellant.

\_\_\_\_\_ /

**Docket No. 15-011526 HHS**

**Case No. ██████████**

**DECISION AND ORDER**

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

After due notice, a telephone hearing was held on ██████████. Appellant appeared and testified. ██████████, Appeals Review Officer, and ██████████, Adult Services Worker, appeared to testify on behalf of the Michigan Department of Health and Human Services (MDHHS or the Department).

**ISSUE**

Did the Department properly determine that Appellant's start date for Home Health Services (HHS) was ██████████?

**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 benefit recipient.
2. On, ██████████, the Adult Services worker sent the Appellant a Services and Payment Approval Notice, informing her that the assessment had been completed and that she is eligible for Home Help Services.
3. The Notice indicated that the provider needed to complete enclosed paperwork for payments to begin and to provide identification. In addition, after the paperwork was received a background check would need to be completed.
4. On ██████████, another Services and Payment Approval Notice was

sent to Appellant, informing her that her provider had been approved and monthly payments in the amount of \$ [REDACTED] would begin on J [REDACTED] [REDACTED].

5. On [REDACTED], Appellant filed a request for a hearing stating that her provider began working on [REDACTED] and requesting retroactive HHS payments for the months of [REDACTED], [REDACTED] and early [REDACTED].
6. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing, protesting the start date of HHS payments and asking for payment for [REDACTED] through [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 Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services 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 101 (11-1-2011) (hereinafter "ASM 101") addressed the issue of payment services for Home Help at the time of the denial in this case:

#### **Payment Services for 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.

Home Help Services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are not currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care

facility (ICF) for persons with developmental disabilities or institution for mental illness.

These activities must be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. The medical professional does not prescribe or authorize personal care services. Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

ASM 120, page 1, specifically states:

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.

Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened for supportive services to assist the client in applying for Medicaid (MA).

Home help services payments cannot be authorized prior to establishing Medicaid eligibility and completing a face-to-face assessment with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.

- Need for service, based on a complete comprehensive assessment indicating a functional limitation of level 3 or greater for at least one activity of daily living (ADL).
- Appropriate Level of Care (LOC) status. ASM 105, page 1

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

- 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. ASM 105, page 3

A referral may be received by phone, mail or in person and must be entered on ASCAP upon receipt. The referral source does not have to be the individual in need of the services. The adult services specialist must determine eligibility within the 45 day standard of promptness which begins from the time the referral is received and entered on ASCAP. The referral date entered on ASCAP must be the date the referral was received into the local office. The computer system calculates the 45 days beginning the day after the referral date and counting 45 calendar days. If the due date falls on a weekend or holiday, the due date is the next business day.

When a signed DHS-390 serves as the initial request for services, the referral date must be the date the application was received in the local office. ASM 110, page 1

Moreover, with respect to the authorization of payments, Adult Services Manual 140 (11-1-2011) (hereinafter "ASM 140") states:

#### **ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)**

The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. The Adult Services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.

*No payment can be made unless the provider has been enrolled in Bridges. Adult foster care, homes for the aged and home help agency providers must also be registered with Vendor Registration; see ASM 136, Agency Providers.*

**Note:** The adult services home page provides a link to the provider enrollment instructions located on the Office of Training and Staff Development web site.

Home help services payments to providers must be:

- *Authorized for a specific period of time and payment amount.* The task is determined by the comprehensive assessment in ASCAP and will automatically include tasks that are a level three or higher.
- Authorized **only** to the person or agency actually providing the hands-on services.

**Note:** An entity acting in the capacity of the client's fiscal intermediary is not considered the provider of home help and must not be enrolled as a home help provider; see ASM 135, Home Help Providers.

- Made payable jointly to the client and the provider.

**Exception:** Authorizations to home help agency providers are payable to the provider only. There are circumstances where payment authorizations to the provider only are appropriate, for example, client is physically or mentally unable to endorse the warrant. All single party authorizations must be approved by the supervisor.

- Prorate the authorization if the MA eligibility period is less than the full month. [ASM 140, page 1 of 3 (italics added).]

Pertinent DHS policy dictates:

The client has the right to choose the home help provider(s). As the employer of the provider, the client has the right to hire and fire providers to meet individual personal care service needs. Home help services is a benefit to the client and earnings for the provider.

The determination of provider criteria is the responsibility of the adult services specialist.

*Adult Services Manual 135, page 1, ASB 2013-004,  
December 1, 2013.*

All home help providers **must** be enrolled in Bridges by a designee at the local county DHS office prior to authorizing payment. Once a provider is enrolled, Bridges will assign the provider a seven digit identification number. The adult services specialist must allow 24 hours from the time of enrollment for Bridges to interface with ASCAP. *ASM 135, page 4.*

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Medical Services Administration Bulletin 14-40 states:

The Michigan Department of Community Health (MDCH) intends to utilize the authority extended to the state though 42 USC 1396t(k)(4) to meet requirements under 42 USC 441.570 to assure that “[n]ecessary safeguards have been taken to protect the health and welfare of enrollees.” This bulletin extends the Medicaid provider criminal history screening and enrollment requirements to individuals who offer personal care services through the Medicaid Home Help personal care services.

Bulletin 14-14 also states:

Beginning October 2, 2014, all new provider applicants must fully meet the provisions of this bulletin before being enrolled to provide services. Providers must be properly enrolled prior to being authorized, approved, or reimbursed to provide personal care services through the Medicaid Home Help Program. (State’s Exhibit A page 16)

In this case, Appellant’s provider began providing services in ██████████ and performed services continuously. The provider would like to be paid for work from the date of referral. Appellant and her provider both testified that they filled out all forms that were sent to them and returned them to the Department in a timely manner. Appellant testified that she contacted the Adult Services Worker’s supervisor, who went through the Food Assistance Program file and found the forms had been returned in ██████████.

The evidence on the record indicates that Appellant’s provider was approved for employment ██████████, once her criminal background check cleared. The Adult Services Worker testified that the Supervisor did find a form that had been misfiled in the Food Assistance Program file but the 4678 Form for Criminal Background checks was not in the Food Assistance Program file. Appellant and her provider came into the office ██████████ to fill out the proper form and the case was approved for payment once the provider passed the background check.

The Department has established by the necessary competent, substantial and material evidence on the record that it was acting in accordance with Department policy when it issued to Appellant Notice that HHS was approved with a start date of ██████████

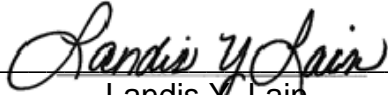
once both the home visit and the all other appropriate documentation paperwork was completed. Even though the Department may have caused the delay this Administrative Law Judge has no equity powers and cannot make a decision in contravention of Department policy.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department has established by a preponderance of the evidence that [REDACTED] was the appropriate begin date for Appellant's HHS case.

**IT IS THEREFORE ORDERED THAT:**

The Department's decision is AFFIRMED.

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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

LYL [REDACTED]

cc: [REDACTED]

**\*\*\* 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 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.