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:

[redacted],

Docket No. 15-015696 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.*, and upon Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified. [redacted], Appeals Review Officer; [redacted], Adult Service Supervisor, and [redacted], Adult Services Specialist 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 [redacted]?

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. Appellant's provider (her granddaughter) started working in [redacted].

3. On [redacted], the Department caseworker conducted a home assessment with Appellant.

4. Appellant is diagnosed with Chronic Obstructive Pulmonary disease, Hypertension, Lumbar Degenerative Disc Disease and Anxiety.

5. Appellant was given assistance with laundry, shopping, bathing, grooming, housework, laundry and meal preparation. State's Exhibit A page 13

6. On [redacted], an appointment was scheduled with Appellant's provider. The provider did not show for the appointment. The appointment was rescheduled for [redacted].

7. On [redacted], Appellant's provider became officially enrolled and passed the background check.

8. Appellant was receiving HHS.

9. On [redacted], the worker completed a six month review and determined that there was no change in Appellant's condition but she needed help with meals as she was no longer receiving Meals on Wheels. State's Exhibit A page 7

10. On [redacted] the Adult Services Worker had a telephone conversation with Appellant about the amount of her Home Help grant. Appellant wanted her amount increased because she stated that her sister received about $[redacted] per month in HHS.

11. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing, protesting the the start date of HHS payments and asking for payment for [redacted] forward.

12. On [redacted], the worker received a telephone call from Appellant's provider informing the worker that she no longer wished to continue working for Appellant and that her last day on the job would be [redacted].

13. The caseworker stopped HHS payments effective [redacted] in response to the provider's request for termination.

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.*

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

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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.

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> **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.
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> - Made payable jointly to the client and the provider.
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> **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).]

In this case, Appellant's provider began providing services in [redacted] and performed services continuously. The provider would like to be paid for work from the date of referral.

The evidence on the record indicates that the Department conceded on the record that the home visit was conducted in a delayed fashion. The caseworker testified that Appellant provided all necessary documentation in [redacted], but she was not able to conduct the home visit until [redacted]. The provider was not approved for enrollment into the program until [redacted], once she passed the background check. The provider was paid for services provided from [redacted] until [redacted].

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 [redacted] once both the home visit and the all other appropriate documentation paperwork was completed and the provider enrolled in the program. Even though the Department 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 Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

LYL/[redacted]

cc: [redacted]

Date Signed: [redacted]

Date Mailed: [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. 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.