STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2011-26271 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 the Appellant's request for a hearing.

After due notice, a hearing was held by telephone on [redacted], [redacted], Appellant's legal guardian and sister, appeared on behalf of the Appellant. [redacted], Appellant's sister and chore provider, and [redacted], Appellant's Case Manager at [redacted] Community Mental Health (CMH), also testified on Appellant's behalf.

[redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Appellant's Adult Services Worker (ASW) at the [redacted] DHS-HHS Office, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's application for 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 [redacted] year-old woman.

2. Appellant, through her legal guardian, applied for HHS at a time when she was a Medicaid beneficiary. (Testimony of [redacted] and [redacted]).

3. On [redacted], ASW [redacted] sent Appellant an Adequate Negative Action Notice notifying Appellant that her request for HHS was being denied. (Exhibit 1, pages 5-7).

4. The reason given in the Adequate Negative Action for the denial was that the Disability Network was already paying for in-home service and, therefore, Appellant was ineligible to receive HHS. (Exhibit 1, pages 5-7).

5. The Disability Network is affiliated with [redacted] CMH. (Testimony of [redacted]).

6. On [redacted], the Department received Appellant's Request for Hearing. In that request, Appellant's legal guardian states that Appellant needs HHS and that the [redacted] CMH would not authorize any services until a decision was made with respect to HHS. (Exhibit 1, page 4).

7. As of [redacted], Appellant no longer qualified for Medicaid. (Exhibit 1, page 8; Testimony of [redacted]).

8. Appellant is not eligible for or receiving Medicaid at this time. (Testimony of [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 Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

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

Adult Services Manual 361 (6-1-07) (hereinafter "ASM 361"), Adult Services Manual 362 (12-1-07) (hereinafter "ASM 362") and Adult Services Manual 363 (9-1-08) (hereinafter "ASW 363") address the situation where an applicant may be eligible for HHS as well as benefits from other agencies or sources. As provided in those manuals, while HHS may not duplicate services from other sources, the Department should coordinate its services with other agencies.

With respect to the duplication of services:

> **Service Plan Development**
>
> Address the following factors in the development of the service plan:
>
> ***

- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for same time period).

(ASM 363, pages 4-5 of 24)

Services not Covered by Home Help Services

Do **not** authorize HHS payment for the following:

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- Services provided by another resource at the same time;

(ASM 363, page 14 of 24)

With respect to the coordination of benefits:

PARTNERSHIPS

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 of services.

(ASM 361, page 4 of 5)

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.

(ASM 362, page 3 of 5)

Good Practices

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- Monitor and document the status of all referrals to waiver programs and other community resources to ensure quality outcomes.

(ASM 363, pages 5-6 of 24)

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.

(ASM 363, page 11 of 24)

In this case, it is unclear exactly what services Appellant was receiving from the Disability Network. [redacted] testified that, at the time of the assessment, she was told that Appellant was receiving services for all Instrumental Activities of Daily Living (IADL) and transportation. [redacted] did not see a care plan. [redacted] testified that Appellant was receiving 13 hours a week for services such as transportation, cleaning, cooking, and other daily activities. According to [redacted], some of those services took the form of hands-on assistance while others only involved reminding or prompting. [redacted] testified that assisting, reminding and prompting are generally what Appellant needs.

Assisting, reminding, and prompting are not covered by HHS. ASM 363, page 4 of 24. However, Appellant was receiving services in other areas that could be encompassed by HHS. Moreover, while HHS should be denied if there is a duplication of services, the Adult Services Manuals applicable to HHS also provide that an ASM is to coordinate benefits with other agencies and resources. Therefore, rather than simply denying HHS outright at the time of the assessment, the Department should have explored the possibility of coordinating its benefits with the other services.

Nevertheless, even if there should have been an attempt to coordinate benefits at the time of the assessment, the Department's decision must still be affirmed. As discussed above, Appellant became eligible for Medicaid during the course of this case and ASM 363 addresses the necessity of Medicaid eligibility for receiving Home Help Services:

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 of 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 (sic) 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.

(ASM 363, page 7 of 24)

The Department must implement its programs in accordance with its policies and the Department policy listed immediately above mandates that a person must be eligible for Medicaid or the monthly spend-down must be met in order to receive HHS. Neither of those circumstances are present here and Appellant is undisputedly ineligible for HHS at this time.

Appellant was eligible for Medicaid at the time she applied and the Department should have explored coordinating her benefits rather than denying her application outright. However,

even if the Department had done so, her HHS benefits would have terminated once she became ineligible for Medicaid. There may have been a brief period where Appellant would have received some HHS, but that is impossible to determine at this point given the absence of a comprehensive assessment on Appellant's needs, the policy against duplication of services, the lack of specific testimony regarding what services Appellant was receiving, and the inability to coordinate benefits now. Similarly, awarding any such services retroactively is just as unfeasible given the above factors and the absence of testimony regarding the services the chore provider has been supplying since the denial of Appellant's application.

If Appellant becomes eligible for Medicaid and HHS in the future, she can then reapply for HHS. In processing her application, the Department should coordinate benefits with other agencies as required.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that, while the Department may have erred by failing to explore the possibility of coordinating benefits, payments for HHS cannot be awarded retroactively in this case and Appellant is not currently eligible for Medicaid or HHS.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/24/2011

***** NOTICE *****

The Michigan Administrative Hearings 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 Hearings 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.