**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2012-49434 HHS

Case No.

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 on Guardian, appeared on the Appellant's behalf. , the Appellant, was present . Appeals Review Officer, represented the Department. , Adult Services Worker, and Adult Services Supervisor, appeared as witnesses for the Department.

**ISSUE**

Did the Department properly reduce the Appellant's Home Help Services ("HHS") payment due to a Medicaid spend-down?

**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 had been authorized for Home Help Services.

2. The Appellant was authorized for 95 hours and 11 minutes of HHS per month with a total monthly care cost of $761.39. (Exhibit 1, page 22)

3. The Appellant has a monthly deductible, or spend-down, that must be met to be eligible for Medicaid for the remainder of each month. The Appellant's monthly Medicaid spend-down was $456 in 2011. (Exhibit 1, page 18)

4. On , the Appellant received a notice, in part, indicating her Medicaid spend-down would change effective . (Exhibit 1, page 6)

5. On the Department issued an Advance Negative Action notice to the Appellant indicating her HHS payment would be reduced to $279.54 effective because there was a spend-down amount of $456 that would be deducted from the care cost. (Exhibit 1, pages 10-13)

6. The Appellant appealed, in part, the change in her Medicaid spend-down. (Exhibit 1, page 6)

7. The Department suspended the reduction in the Appellant's HHS payments pending the outcome of the hearing regarding the Medicaid spend-down determination. (Adult Services Supervisor Testimony)

8. On Administrative Law Judge ("ALJ") issued a Hearing Decision, in part, reversing the change in the Appellant's Medicaid spend-down, ordering reprocessing the Appellant's Medicaid benefits and supplementing the Appellant for lost benefits she was eligible and otherwise qualified to receive but for the negative action. (Exhibit 1, pages 5-8)

9. The Appellant's monthly Medicaid spend-down changed to $452 for the period of and increased to $485 effective (Exhibit 1, page 18)

10. Effective the Appellant's monthly HHS payment was reduced to $283.40 based on the spend-down. (Exhibit 1, page 20, Adult Services Supervisor Testimony)

11. On the Appellant's Request for Hearing was received by the Michigan Administrative hearing System. (Exhibit 1, page 4)

12. On the Department issued an Advance Negative Action notice to the Appellant indicating her HHS payment would be reduced to $253.17 effective because of the spend-down of $485. (Exhibit 1, pages 14-17)

**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.

The Adult Services Manual (ASM) addresses eligibility for Home Help Services. The policy at the time of the Appellant applied for HHS stated:

> **<u>ELIGIBILITY FOR HOME HELP SERVICES</u>**
>
> 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.
>
> **<u>Medicaid/Medical Aid (MA)</u>**
>
> 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.
>
> **Medicaid Personal Care Option**
>
> Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and the ES.

Conditions of eligibility:

- The client meets all MA eligibility factors except income.
- An ILS services case is active on CIMS (program 9).
- The client is eligible for personal care services.
- The cost of personal care services is **more** than the MA excess income amount.
- The client agrees to pay the MA excess income amount to the home help provider.

*Adult Services Manual (ASM) 363, 9-1-2008 pages 7-8 of 24.*

The Adult Service Manual Policy was updated effective November 1, 2011:

**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.

**Medicaid/Medical Aid (MA)**

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).

Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

**Note:** A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and coordinate implementation with the eligibility specialist.

Conditions of eligibility:

- The client meets all Medicaid eligibility factors except income.
- An independent living services case is open.
- The client is eligible for home help services.
- The cost of personal care services is **more** than the MA excess income amount.

If **all** the above conditions have been satisfied, the client has met MA deductible requirements. The adult services specialist can apply the personal care option in ASCAP. The deductible amount is entered on the **MA History** tab of the Bridges **Eligibility** module in ASCAP.

Use the DHS-1210, Services Approval Notice to notify the client of home help services approval when MA eligibility is met through this option. The notice must inform the client that the home help payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA deductible amount each month.

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

Changes in the client's deductible amount will generate a system tickler from Bridges.

MA eligibility under this option **cannot** continue if the cost of personal care becomes **equal to or less than** the MA excess income amount.

Adult Services Manual (ASM) 105, 11-1-2011 pages 1-2 of 3

Adult Services Manual (ASM 150, 11-1-2011), pages 1-4 addresses notification of eligibility determinations:

**INTRODUCTION**

Individuals who submit an application (DHS-390) for home help services or adult community placement must be given written notification of approval or denial for services. A written notice must be sent within the 45 day standard of promptness.

Clients with active service cases must be provided written notice of any change in their services (increase, reduction, suspension or termination).

**Written Notification of Disposition**

All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.
- DHS-1212, Advance Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

The adult services specialist **must sign** the bottom of the second page of all notices (DHS-1210, DHS-1212A, DHS-1212) before they are mailed to the client.

***

**Advance Negative Action Notice (DHS-1212)**

The DHS-1212, Advance Negative Action Notice, is used and generated on ASCAP when there is a reduction, suspension or termination of services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

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

***

Negative Actions Requiring Ten Day Notice

The effective date of the negative action is ten business days **after** the date the notice is mailed to the client. The effective date must be entered on the negative action notice.

If the client does not request an administrative hearing before the effective date, the adult services specialist must proceed with the proposed action.

If the client requests an administrative hearing before the effective date of the negative action, and the specialist is made aware of the hearing request, continue payments until a hearing decision has been made. If the specialist is made aware of the hearing request **after** payments have ended, payments must be reinstated pending the outcome of the hearing. Offer the client the option of discontinuing payment pending the hearing decision.

**Note:** When payments are continued pending the outcome of a hearing, the client must repay any overpayments if the department's negative action is upheld. Initiate recoupment procedures by sending the client a Recoupment Letter.

Negative Actions Not Requiring Ten Day Notice

The following situations **do not** require the ten business day notice on negative actions:

- The department has factual confirmation of the death of the client (negative action notice must be mailed to the guardian or individual acting on the client's behalf) or death of the service provider.

**Note:** Cases should remain open until all appropriate payments have been issued.

- The department receives a verbal or written statement from the client, stating they no longer want or require services, or that they want services reduced.

**Note:** This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The department receives a verbal or written statement from the client that contains information requiring a negative action. The statement must acknowledge the client is aware the negative action is required **and** they understand the action will occur.

**Example:** A home help services client informs the specialist that they are engaged and will be married on a specific date. They also acknowledge that their new spouse will be responsible for meeting their personal care needs and they will no longer qualify for home help services.

**Note:** This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The client has been admitted to an institution or setting (for example, hospital, nursing home) where the client no longer qualifies for federal financial participation under the Medicaid State Plan for personal care services in the community.

**Note:** When a client is admitted to a hospital or nursing home, the facility is reimbursed for the client's care on the day the client is admitted, but not for the day of discharge. The home help provider cannot be reimbursed for the date the client is admitted to the facility but may be paid for the day of discharge.

- The client cannot be located and the department mail directed to the client's last known address has been returned by the post office indicating the forwarding address is unknown.

**Note:** In this circumstance, a services payment must be made available if the client is located during the payment period covered by the returned warrant.

- The client has been accepted for services in a new jurisdiction and that fact has been established by the jurisdiction previously providing services.

- The time frame for a services payment, granted for a specific time period, has elapsed. The client was informed, in writing, at the time payments were initiated, that services would automatically terminate at the end of the specified period.

**Example:** The DHS-1210 clearly states a begin and end date for the services payments.

*Adult Services Manual (ASM) 150, 11-1-2011, Pages 1-4*

The Appellant's needs for assistance at home were not contested in this case. Rather, changes in the Appellant's HHS payment were based on her Medicaid spend-down status. The Appellant's Guardian asserted that the Appellant should not have a spend-down. As noted during the telephone hearing proceedings, this ALJ does not have jurisdiction over the Medicaid spend-down determinations. The scope of this hearing is limited to the actions taken on the Appellant's HHS case. The Appellant's Request for Hearing has been forwarded for separate hearing proceedings regarding Medicaid spend-down determinations since Hearing Decision.

Department policy requires a HHS participant to have Medicaid coverage with a qualifying scope of coverage in order to be eligible for the HHS program. Individuals who have met their monthly Medicaid deductible, or spend-down, are eligible for HHS. An individual with a spend-down can also become eligible for HHS if the monthly care cost exceeds the spend-down and the individual agrees to pay the HHS provider the spend-down amount. *Adult Services Manual (ASM) 363, 9-1-2008 pages 7-8 of 24, Adult Services Manual (ASM) 105, 11-1-2011, pages 1-2 of 3.*

The Appellant was authorized for 95 hours and 11 minutes of HHS per month with a total monthly care cost of $761.39. (Exhibit 1, page 22) On the Department issued an Advance Negative Action notice to the Appellant indicating her HHS payment would be reduced to $279.54 effective September 19, 2011, because there was a spend-down amount of $456 that would be deducted form the care cost. (Exhibit 1, pages 10-13) This notice failed to actually provide advance notice of the reduction as the effective date was prior to the date the notice was issued. However, the Adult Services Supervisor testified that the Department did not implement this reduction because the Appellant had filed a timely appeal contesting the Medicaid spend-down determination that had an effective date of The Adult Service Supervisor explained that she sought clarification and was advised to hold off implementing the reduction the Appellant's HHS payment until a determination was made on the Medicaid spend down appeal. (Adult Services Supervisor Testimony) The payment history shows a retroactive payment for the period of September 1, 2011 through which appears to have corrected the proposed reduction based on the spend-down. (Exhibit 1, page 20)

On issued a Hearing Decision, in part, reversing the October 1, 2011 change in the Appellant's Medicaid spend-down, ordering reprocessing the Appellant's Medicaid benefits, and supplementing the Appellant for lost benefits she was eligible and otherwise qualified to receive but for the negative action. (Exhibit 1, pages 5-8) Accordingly, the Department could not proceed with the HHS payment reduction proposed on the Advance Negative Action Notice. The Appellant's Guardian asserted that the Appellant's HHS payments should be reinstated to the full HHS authorization without reduction for the spend-down amount back to However, ALJ Bradley's decision was specific to the change in the Appellant's Medicaid spend down with an effective date and did not affect the Appellant's Medicaid spend-down status back to April 2011. As noted above, the Department properly supplemented the Appellant's HHS payments for the only months they had reduced the HHS payment due to the change in the Appellant's Medicaid spend down. (Exhibit 1, page 20)

It is not clear how soon after the Hearing Decision a new determination was made regarding the Appellant's Medicaid benefits. The Appellant's monthly Medicaid spend-down changed to $452 for the period o through and increased to $485 effective (Exhibit 1, page 18)

Effective the Appellant's HHS payment was reduced to $283.40 based on the spend-down. (Exhibit 1, page 20, Adult Services Supervisor Testimony) The contact history does not show any Advance Negative Action Notice was issued regarding the reduction. (Exhibit 1, pages 10-17) None of the exceptions to the requirement for advance notice were present for this action. Accordingly, the reduction can not be upheld because no advance written notice was issued to the Appellant.

On the Department issued an Advance Negative Action notice to the Appellant indicating her HHS payment would be reduced to $253.17 effective because of the spend-down of $485. (Exhibit 1, pages 14-17) This reduction in the Appellant's HHS payment is based on the new spend down amount that went into effect (Exhibit 1, pages 14-18) This notice did provide the required 10 business day advance notice of the reduction. However, the payment authorization history indicates the reduction to $253.17 was incorrectly implemented (Exhibit 1, page 20) This reduction to the Appellant's HHS payment is upheld, but can not be effective until

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly reduced the Appellant's HHS payment for the period of [redacted] through [redacted] because no advance written notice of the reduction was issued to the Appellant.

**IT IS THEREFORE ORDERED** THAT:

The Department's decision is PARTIALLY REVERSED. The reduction to the Appellant's HHS payment can not be effective until [redacted]

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Signed: ____________________

Date Mailed: 7/5/2012

***** 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.