/STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF COMMUNITY HEALTH

IN THE MATTER OF:

[redacted]

Docket No. 2012-64532
Case No. 34179972
Hearing Date: October 24, 2012

ADMINISTRATIVE LAW JUDGE: Jennifer Isiogu

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Appellant's request for a hearing. After due notice a telephone hearing was held on the above referenced date. The Appellant appeared and testified. Participants on behalf of the Department of Community Health (Department) included Allison Pool, Appeals Review Officer and Sharonda Campbell, Adult Services Supervisor.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services benefits case?

FINDINGS OF FACT

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

1. The Appellant was a Medicaid beneficiary and Home Help Services (HHS) participant until June 30, 2012.

2. The Appellant's Medicaid benefits terminated June 30, 2012.

3. On July 11, 2012, the ASW sent the Appellant notification that he was not eligible for HHS and his benefits under the program were discontinued because he was no longer eligible for Medicaid as of June 30, 2012.

4. The Appellant has a medical need for HHS assistance as his medical condition has not improved.

5. On July 20, 2012, the Michigan Administrative Hearing System received the Appellant's Request for Hearing.

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 Department of Community Health HHS Medicaid policy is found in the Department of Human Services Adult Services Manual (ASM) at ASM 100- 170. ASM 110, pp. 1-2 provides that HHS policy for the HHS referral intake and registration. ASM 110 provides in pertinent part:

REFERRAL INTAKE

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.

Registration and Case Disposition

Action	Complete a thorough clearance of the individual in the ASCAP client search and Bridges search. Complete the **Basic Client** and **Referral Details** tabs of the **Client** module in **ASCAP**. Supervisor or designee assigns case to the adult services specialist in the **Disposition** module of **ASCAP**.
Documentation	Print introduction letter, the DHS-390, Adult Services Application and the DHS-54A, Medical Needs form and mail to the client. The introduction letter allows the client 21 calendars days to return the documentation to the local office. **Note:** The introduction letter does **not** serve as adequate notification if home help services are denied. The specialist must send the client a DHS-1212A, Adequate Negative Action Notice; see ASM 150, Notification of Eligibility Determination.

Standard of Promptness (SOP)

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.

Note: A medical need form does not serve as an application for services. If the local office receives the DHS-54A, a referral must be entered on ASCAP for the date the form was received in the local office and an application sent to the individual requesting services.

After receiving the assigned case, the adult services specialist gathers information through an assessment, contacts, etc. to make a determination to open, deny or withdraw the referral; see ASM 115, Adult Services Requirements.

ASM 110, pp. 1-2.

ASM 105, pp. 1-3 provides HHS policy for the HHS eligibility. ASM 105 provides in pertinent part:

GENERAL

Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened to supportive services to assist the client in applying for Medicaid. Home help services payments cannot be authorized prior to establishing Medicaid eligibility and a face-to-face assessment completed with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

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 service 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.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. A completed DHS-54A or veterans administration medical form are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

ASM 105, pp. 1-2.

On July 11, 2012, the Appellant's Adult Services Worker was forced to send the Appellant a Negative Action Notice informing him his HHS benefits could not continue because his Medicaid eligibility ended June 30, 2012. The Appellant's medical condition is unchanged. The determination had no relationship to his medical/functional status.

The Appellant did not contest the legal basis for the Department's action. His evidence includes uncontested assertions that he is an amputee and dependent upon an electric scooter for mobility. He is aged and suffering from diabetes. Furthermore, he has a mass on a kidney.

The Department's determination was based solely upon its own business records indicating the Appellant was no longer eligible for Medicaid effective June 30, 2012. This is not a fact which can be altered or remedied by this ALJ. The Appellant is strongly encouraged to seek assistance with re-establishing Medicaid eligibility through the Department of Human Services and/or Area Agency on Aging. He is also strongly encouraged to re-apply for this program when he re-establishes Medicaid eligibility.

Based upon the above Findings of Fact and Conclusions of Law, the Administrative Law Judge concludes that the Department properly terminated the Appellant's HHS application

DECISION AND ORDER

The Administrative Law Judge, based upon the above Findings of Fact and Conclusions of Law, finds that the Department did act properly.

Accordingly, the Department's Home Help Services decision is AFFIRMED

/S/
Jennifer Isiogu
Administrative Law Judge
For James K. Haveman, Director
Michigan Department of Community Health

Date Mailed: 2/26/2013

cc: [redacted]

NOTICE: The Michigan Administrative Hearing System (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. MAHS will not order a rehearing or reconsideration on the Department's motion where the final decision 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 date of the rehearing decision.

Appellant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:

  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the Appellant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at

Michigan Administrative Hearing System
Reconsideration/Rehearing Request
P. O. Box 30763
Lansing, Michigan 48909