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) 373-4147

IN THE MATTER OF:

Docket No. 2013-23484 HHS

[redacted] [redacted] [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 [redacted] [redacted] caregiver, represented the Appellant. [redacted] the Appellant, appeared and testified. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker ("ASW"), [redacted] AP Manager, [redacted] ASW, and [redacted] Adult Services Supervisor, appeared as witnesses for the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services ("HHS") case?

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 was formerly a full coverage Medicaid beneficiary receiving HHS.

2. Since [redacted] the Appellant had been authorized for HHS with a total monthly care cost of [redacted]. (Exhibit 1, pages 19 and 22)

3. The Appellant's Medicaid status indicates she had a deductible, or spend-down (scope of coverage code 2C), that must be met each month before Medicaid coverage is active (scope of coverage code 2F) for the remainder of that month. The Appellant's monthly spend-down was [redacted] from [redacted] through [redacted] and [redacted] from

[redacted] through [redacted] The scope of coverage code remains 2C for these time periods, indicating the monthly spend-downs were not met. (Exhibit 2)

4. Department policy requires Medicaid eligibility scope of coverage of 1F, 2F, 1D, 1K, or 1T in order to receive HHS. Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation. (Adult Services Manual (ASM) 105, [redacted] pages 1-2 of 3)

5. The Appellant's monthly Medicaid spend-down, [redacted] or [redacted], exceeded the total monthly care cost of HHS, [redacted], for which the Appellant was potentially eligible.

6. On [redacted] the Department sent the Appellant an Advance Negative Action Notice which informed her that the HHS case would be terminated effective [redacted] because her Medicaid has been on a spend-down with no active coverage since [redacted] and there has been no activity on the HHS program. (Exhibit 1, page 6)

7. Between [redacted] and [redacted] the Michigan Administrative hearing System received the Appellant's Requests 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 Adult Services Manual (ASM) addresses eligibility for Home Help Services:

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*

Department policy requires a HHS participant to have full coverage Medicaid or have met the monthly Medicaid spend-down, in order to be eligible for the HHS program. The Appellant's Medicaid status indicates she had a deductible, or spend-down (scope of coverage code 2C), that must be met each month before Medicaid coverage is active (scope of coverage code 2F) for the remainder of that month. The Appellant's monthly spend-down was [redacted] from [redacted] through [redacted] and [redacted] from [redacted] through [redacted]. The scope of coverage code remains 2C for these time periods, indicating the monthly spend-downs were not met. (Exhibit 2) In [redacted], the ASW determined the Appellant's HHS case must be terminated because there was an un-met monthly spend-down and no active Medicaid for three months, since [redacted]. (ASW Testimony)

The requests for hearing, as well as the testimony of the Appellant and her caregiver, indicate they believe the spend-down determinations are incorrect because the Appellant met her Medicaid spend-downs from [redacted] through [redacted] (Appellant Testimony; Caregiver Testimony; Requests for Hearing) As discussed during the telephone hearing proceedings, this ALJ does not have jurisdiction over the Medicaid determinations. The Appellant's Requests for Hearing and subsequent written request for an in-person hearing have been forwarded to be processed for separate hearing proceedings on the Medicaid determinations.

The Department's documentation establishes that the Appellant had Medicaid a spend-down of [redacted] per month from [redacted] through [redacted] and [redacted] per month from [redacted] through [redacted] The scope of coverage code remains 2C for this time period, indicating the monthly spend-downs were not met. (Exhibit 2) The monthly spend-down amounts, [redacted] or [redacted], exceeded the total monthly care cost of the Appellant's HHS authorization, [redacted]. (Exhibit 1, page 19; Exhibit 2) Therefore, the Appellant was no longer eligible to receive HHS and the [redacted] termination of her HHS case was appropriate.

The Appellant can always re-apply for HHS if there are any changes to her Medicaid eligibility status.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly terminated the Appellant's HHS case.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]
Date Mailed: [redacted]

CL/db

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.