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. 2013-30103 HHS

[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] the Appellant, appeared on her own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker ("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. On or about [redacted], the Appellant applied for the HHS. (Exhibit 1, page 14)

2. The ASW completed an initial assessment of the Appellant's HHS case and determined the Appellant was potentially eligible for [redacted] hours and [redacted] minutes of HHS per month with a total monthly care cost of [redacted]. (Exhibit 1, pages 16-17)

3. Department policy requires Medicaid eligibility with a scope/coverage code of 1F, 2F, 1D, 1K, or 1T in order to receive Home Help Services. (Adult Services Manual (ASM) 105, November 1, 2011, pages 1-2 of 3)

[redacted]

4. The Appellant was a Medicaid beneficiary, scope/coverage code 1F, from [redacted] through [redacted] (Exhibit 1, page 18)

5. On [redacted] the Department sent the Appellant a Services and Payment Approval Notice to the Appellant, which informed her that she was approved for HHS with a monthly care cost of [redacted] with a start date of [redacted] (Exhibit 1, pages 8-9)

6. On [redacted], the Department also sent the Appellant an Advance Negative Action Notice which informed her that the HHS case would be terminated with an effective date of [redacted]. The reason for this action stated "effective [redacted] your case will become ineligible to receive HHS due to you lack of Medicaid Coverage." The contact information for the Medicaid case worker was also listed. (Exhibit 1, pages 5-7)

7. On [redacted] the Department sent the Appellant an Advance Negative Action Notice which informed her that the HHS case terminated [redacted] and her HHS case closed because she no longer had Medicaid coverage. (Exhibit 1, pages 10-13)

8. The Department authorized HHS payments for the Appellant from [redacted] through [redacted] (Exhibit 1, page 19)

9. On [redacted], the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1 page 4)

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:

[redacted]

- 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.

[redacted]

- 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

The Appellant's needs for assistance at home were not contested in this case. Rather, the Appellant's HHS case was terminated due to the change in her Medicaid status after [redacted].

Department policy requires Medicaid eligibility with a scope/coverage code of 1F, 2F, 1D, 1K, or 1T in order to receive Home Help Services, or have met the monthly Medicaid spend-down, in order to be eligible for the HHS program. The Appellant was a Medicaid beneficiary, scope/coverage code 1F, from [redacted] through [redacted]. (Exhibit 1, page 18) Accordingly, the Department properly authorized HHS payments for the Appellant from [redacted] through [redacted]. (Exhibit 1, page 19) The Department could not continue to authorize HHS payments for the Appellant after her Medicaid eligibility ended. While there was a slight typographical error in the listed effective date, the Appellant was sent advance notice at least 10 business days before [redacted] that her HHS payments would terminate due to the change in her Medicaid eligibility status. Further,

[redacted]

the notice provided the Appellant contact information for her Medicaid case worker. (Exhibit 1, pages 5-7) As of [redacted], the Appellant did not have Medicaid coverage. (ASW Testimony) Accordingly, the Appellant's HHS case was closed on [redacted]. (Exhibit 1, page 14)

The Appellant's testimony indicated she still needs services because she still can not use her hands for daily activities. The Appellant also understood that her Medicaid coverage was turned back on as of [redacted] (Appellant Testimony)

The Adult Services Supervisor testified that the Appellant's Medicaid eligibility status changed again effective [redacted], however, the scope/coverage code is 3G. (Adult Services Supervisor Testimony) This is not a scope/coverage code that would allow for current HHS eligibility.

The evidence is uncontested that the Appellant's Medicaid coverage ended [redacted] and no change in her Medicaid eligibility status occurred until [redacted]. The Appellant was no longer eligible to receive HHS after [redacted] and by [redacted] her Medicaid status had not changed. The Department's determinations to stop the Appellant's HHS payments after December 31, 2012 and to close her HHS case on [redacted] were appropriate based on the available information and must be upheld.

The Appellant can always re-apply for HHS if she there is a change in Medicaid eligibility status that would allow for HHS eligibility.

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]

[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.

CL/db

cc: [redacted]