

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████,

Appellant

Docket No. 2013-17102 HHS

Case No. ██████████

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 ██████████. ██████████, the Appellant, appeared on her own behalf. ██████████, Appeals Review Officer, represented the Department. ██████████, Adult Services Worker ("ASW"), and ██████████, General Services Program Manager, 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 ██████████, the Appellant had been authorized for HHS with a total monthly care cost of ██████████. (Exhibit 1, pages 12-13)
3. The Appellant's Medicaid status changed from full coverage Medicaid with a scope of coverage of 1F to having a deductible, or spend-down, of ██████████ with a scope of coverage of 2C effective ██████████. (Exhibit 2)

4. Department policy requires Medicaid eligibility 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, November 1, 2011, pages 1-2 of 3)
5. The Appellant's Medicaid spend-down exceeds the total monthly care cost of HHS for which she is 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] based on the change in her Medicaid status. (Exhibit 1, pages 5-8)
7. 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:

- 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

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

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 had been a full coverage Medicaid with a scope of coverage of 1F. Effective ██████████, the Appellant's Medicaid eligibility changed to having a monthly Medicaid spend-down in the amount of ██████████ with a scope of coverage of 2C. (Exhibit 2) Since ██████████, the Appellant had been authorized for HHS with a total monthly care cost of ██████████. (Exhibit 1, pages 12-13) The ASW had been informed of the spend-down by the Eligibility Specialist assigned to the Appellant's Medicaid case. The ASW determined the Appellant's HHS case must be terminated because there was an un-met monthly spend-down of ██████████, which exceeded the monthly HHS care cost of ██████████. (ASW Testimony)

The Appellant's testimony indicated she believes the spend-down determination is incorrect and was based on an error with her rent. (Appellant Testimony) As discussed during the telephone hearing proceedings, this ALJ does not have jurisdiction over the Medicaid determination. The Appellant's Request for Hearing has been forwarded for separate hearing proceedings on the Medicaid determination.

The Department's documentation establishes that the Appellant's Medicaid status changed to having a monthly spend-down in the amount of ██████████ effective ██████████ (Exhibit 2) The monthly spend down exceeds the monthly care cost of the Appellant's HHS authorization, ██████████. (Exhibit 1, pages 12-13) There was no

