

**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:

██████████,

Appellant

Docket No. 2013-52405 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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held ██████████. Appellant appeared and testified on her own behalf. ██████████ and ██████████ were also present as witnesses for Appellant. ██████████, Appeals Review Officer, represented the Department of Community Health (DCH). ██████████ and ██████████, Adult Services Workers ("ASWs") at the ██████████ DHS office, 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. Appellant is a ██████ year-old female who has been diagnosed with, among other conditions, degenerative disc disease; hypertension; obesity; arthritis; tendonitis; anxiety; and restless leg syndrome. (Respondent's Exhibit A, page 25).
2. Appellant had been authorized for 18 hours and 3 minutes of HHS per month, with a total monthly care cost of \$██████. (Respondent's Exhibit A, page 27).
3. Starting on ██████████, Appellant had a deductible or spend-down. Her spend-down for ██████████ through ██████████ was \$██████ per month. (Respondent's Exhibit A, page 23).

4. Since it was established, Appellant's monthly Medicaid spend-down has always exceeded the total monthly care cost of the HHS for which she was authorized. (Respondent's Exhibit A, pages 23, 27).
5. In such circumstances, Appellant's Medicaid should have remained inactive until she met her monthly deductible obligation. She would also have to meet that obligation each month. (Testimony of ASW ██████████).
6. Appellant was unaware of any monthly spend-down and never met it between ██████████ and ██████████. (Testimony of Appellant).
7. However, her Medicaid status mistakenly remained active during that entire time period and, based on the active Medicaid, her former case worker continued to authorize full HHS payments. (Respondent's Exhibit A, page 23; Testimony of Appellant).
8. Appellant's spend-down increased on ██████████, and then again on ██████████. (Respondent's Exhibit A, page 23).
9. According to Appellant, she was never notified of any such increases and remained unaware of any spend-down. (Testimony of Appellant).
10. Moreover, her Medicaid status remained active following those increases and she continued to receive HHS payments without meeting her monthly spend-down. (Respondent's Exhibit A, page 23; Testimony of Appellant; Testimony of ASW ██████████).
11. In a Notice of Case Action dated ██████████, the Michigan Department of Human Services (DHS) notified that Appellant's monthly spend-down would be increased to \$ ██████████ beginning ██████████. (Respondent's Exhibit A, page 6).
12. Appellant testified that she never received that Notice of Case Action. (Testimony of Appellant).
13. Also, Appellant's scope of coverage code was changed to "2C" on ██████████. (Respondent's Exhibit A, page 23).
14. Clients with a scope of coverage 2C are not eligible for Medicaid or any Medicaid services until they have met their monthly deductible or spend-down obligation. Additionally, once they do meet that monthly spend-down, their Medicaid is only eligible for the remainder of that month. (Adult Services Manual (ASM) 105, November 1, 2011, pages 1-2 of 3).
15. Appellant has not met her spend-down and her scope of coverage has remained at 2C since ██████████. (Respondent's Exhibit A, page 23).

16. Accordingly her Medicaid has been inactive since that time. (Respondent's Exhibit A, page 23).
17. Moreover, pursuant to policy, no HHS payments have been made since Appellant's Medicaid became inactive. (Testimony of ASW ██████████).
18. On ██████████, the Department sent Appellant an Advance Negative Action Notice stating that her HHS case would be closed effective ██████████ due to her failure to meet her spend-down and her inactive Medicaid. (Respondent's Exhibit A, pages 16-20).
19. On ██████████, the Michigan Administrative hearing System (MAHS) received a Request for Hearing filed by Appellant. The request stated that no HHS payment had been made for ██████████. (Respondent's Exhibit A, pages 4-5).

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.

Adult Services Manual 105, pages 1-2, 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.

The above Department policy therefore 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. Here, 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.

Appellant's monthly spend-down was \$ ██████████ starting ██████████ and her scope of coverage has remained 2C since that time, indicating that the monthly spend-downs were not met. Moreover, while Appellant had previously been receiving HHS while having a spend-down, it appears to have been a mistake and Appellant acknowledges that she has never met a spend-down.

The ASW subsequently determined that Appellant's HHS case must be terminated because there was an un-met monthly spend-down and no active Medicaid since that spend-down was established. The ASW also noted that Appellant's monthly spend-down amount exceeded the total monthly care cost of her HHS authorization and, therefore, the Medicaid Personal Care Option for keeping Appellant's HHS open was not applicable.

In response, Appellant argues that she never received any notice from DHS regarding any spend-down or changes in her Medicaid. However, as discussed during the telephone hearing, this Administrative Law Judge does not have jurisdiction over Medicaid determinations or calculations of spend-downs. DHS has jurisdiction over eligibility issues, not DCH and the ASW must rely on the determinations made at DHS. Appellant has been advised to file a hearing request in the appropriate forum so that a separate hearing can be scheduled to address her concerns with DHS.

Appellant also argues that, given the lack of notice, it would be unfair if her care provider is not paid for services that worker provided in [REDACTED]. However, this Administrative Law has no equitable powers and cannot decide issues as a matter of fairness. Like the Department, this Administrative Law Judge is bound by the applicable policy and, in this case, policy clearly dictates that no payment for HHS can be made for [REDACTED] as Appellant's Medicaid was inactive during that month.

The evidence establishes that the Appellant has a monthly spend-down; she has never met that spend-down; and the monthly spend-down exceeded the total monthly care cost of the Appellant's HHS authorization. Based on that evidence, Appellant was no longer eligible to receive HHS and both the lack of payment in [REDACTED] and the termination of her HHS case were appropriate.

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**.



Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: 8/20/2013

Date Mailed: 8/20/2013

[REDACTED]
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.