

**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. 2013-56596 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. ██████████ and ██████████, friends, appeared as witnesses for the Appellant. ██████████, Appeals Review Officer, represented the Department. ██████████, Adult Services Worker ("ASW"), appeared as a witness for the Department. The Department provided copies of the additional documentary evidence requested by this ALJ at the close of the in-person hearing proceedings, before this ALJ and the Appellant left the Department office.

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 is a Medicaid beneficiary who had been authorized for HHS since ██████████, with a potential total monthly care cost of \$██████████. (Exhibit 1, pages 19 and 21)
2. The Department issued warrants on ██████████, ██████████, and ██████████ for the authorized HHS services provided to the Appellant in ██████████, ██████████, and ██████████. (Exhibit 5)

3. Effective ██████████, the Appellant's Medicaid eligibility changed from full Medicaid coverage (scope 1F) to having a monthly deductible, or spend-down (scope 2C). From ██████████, through ██████████, the Appellant's monthly spend-down was \$██████. Effective ██████████, the Appellant's monthly spend-down increased to \$██████. (Exhibit 1, page 6)
4. Department policy requires Medicaid eligibility in order to receive HHS, and clients with a monthly spend-down are not eligible until they have met their spend-down obligation. (Adult Services Manual (ASM) 105, November 1, 2011, pages 1-2 of 3)
5. On ██████████, the ASW was informed by the Eligibility specialist assigned to the Appellant's Medicaid case of the change in the Appellant's Medicaid eligibility status to having a monthly spend-down. (ASW Testimony)
6. The Appellant's Medicaid spend-down exceeds the total monthly care cost of HHS she is potentially eligible for. (Exhibit 1, pages 6 and 19)
7. On ██████████, the Department sent the Appellant an Advance Negative Action Notice which informed her that the HHS case would be terminated effective ██████████, because of the Medicaid spend-down that went into effect ██████████. The notice explained that chore services cannot be paid unless the full deductible is met. (Exhibit 1, pages 9-12)
8. On ██████████, a Supervisor printed another Advance Negative Action Notice regarding the termination of the Appellant's HHS case so that the hearing rights information could be provided to the Appellant again. (ASW Testimony; Exhibit 1, pages 13-15)
9. On ██████████, the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 1, pages 4-5)
10. The ASW has not received any information from the Eligibility Specialist assigned to the Appellant's Medicaid case or from the Department's computer system indicating the Appellant has met her monthly spend-down since it went into effect ██████████. (ASW Testimony)

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.

HHS Termination

The Appellant's needs for assistance at home were not contested in this case. Rather, the Appellant's HHS case was terminated because she had not met her Medicaid spend-down since it went into effect [REDACTED]. (Exhibit 1, pages 6-7 and 9-12)

The Appellant contests the spend-down determination itself. (Request for Hearing and Appellant Testimony) As explained during the in-person hearing proceedings, this ALJ has no jurisdiction to review the Medicaid eligibility determination made by the Department of Human Services. The Appellant has had multiple administrative hearings regarding the Medicaid eligibility determinations in her case. (Exhibits 2 and 3; Appellant Testimony) The two most recent Hearing Decisions were admitted solely as evidence of the Appellant's Medicaid status for these hearing proceedings. In both Hearing Decisions the ALJ affirmed the Department of Human Service's Medicaid determinations in the Appellant's case. (Exhibits 2 and 3) If the Appellant contests a Hearing Decisions she has a right to appeal that determination. The appeal rights are provided on the last page of the Hearing Decision.

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. There is no evidence that the Department of Human Services has determined that the Appellant met her spend-down since it went into effect [REDACTED]. (Exhibit 1, page 6; ASW Testimony) The Appellant's Medicaid spend-down exceeds the total monthly care cost of HHS she is potentially eligible for. (Exhibit 1, pages 6 and 19) Accordingly, the Appellant has not been eligible for HHS since [REDACTED], and the determination to terminate the Appellant's HHS case must be upheld.

HHS Payment for [REDACTED]

The Appellant asserted that the Department has withheld the HHS payment for the services provided in [REDACTED]. (Appellant Testimony) The Department provided documentation that Warrant number [REDACTED] was issued [REDACTED], for the HHS services rendered to the Appellant in [REDACTED] and that the disposition status of the warrant is paid. (Exhibit 5) Accordingly, the evidence does not support the Appellant's assertion that the HHS payment for services provided in [REDACTED] is being withheld.

Advance Notice

Lastly, the Appellant correctly asserted that the [REDACTED], Advance Action Notice failed to provide actual advance notice of the termination because the effective date of the termination was [REDACTED]. (Appellant Testimony; Exhibit 1, pages 9-12) The evidence establishes no HHS payments were authorized for the Appellant after [REDACTED]. (Exhibit 1, page 21; Exhibit 5)

[REDACTED]
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The ASW testified that she issued the Advance Action Notice as soon as she learned of the change in the Appellant's Medicaid eligibility status on [REDACTED]. The ASW explained that she could not actually provide advance notice of the HHS termination to the Appellant because the change in the Appellant's Medicaid eligibility had already gone into effect [REDACTED], and was un-met, which prevented any additional payment authorizations. Further, the ASW explained that the Eligibility Specialist had issued a notice to the Appellant [REDACTED], which provided advance notice of the change in Medicaid eligibility to a monthly spend-down. (Exhibit 4) This change would then affect any Medicaid covered services, such as HHS. The ASW further asserted that per the application the Appellant signed for the HHS program, the Appellant was responsible for notifying the ASW of any changes within 10 days. Therefore, the Appellant was responsible for informing the ASW of the change in her Medicaid eligibility status within 10 days of receiving the [REDACTED] notice from the Eligibility Specialist. (ASW Testimony)

The Appellant testified that she never received the [REDACTED], notice from the Eligibility Specialist because of the error with how her address was printed on the first page of this notice. (Exhibit 4, page 2) Accordingly, the Appellant never received the advance notice of the change in her Medicaid eligibility status and could not have met any obligation to inform the ASW of this change. The Appellant requested that the HHS provider be paid for at least the services provided through 10 days after the [REDACTED], Advance Action Notice was issued. (Appellant Testimony)

The Adult Services Manual policy and the Code of Federal Regulations set out the Appellant's right to advance notice termination actions. (*Adult Services Manual (ASM) 15o, 11-1-2011 pages 1-4; 42 CFR § 431.211*) It is uncontested that the [REDACTED], Advance Action Notice failed to provide actual advance notice of the HHS termination to the Appellant. Understandably, the Appellant's HHS provider continued providing HHS services to the Appellant in [REDACTED] because there was no advance notice of the HHS termination and the Appellant never received the advance notice of the change in her Medicaid eligibility status. However, these errors do not change the outcome of this case. This ALJ does not have constitutional nor equitable authority. This ALJ cannot order the Department to pay for a Medicaid service provided to the Appellant during a time that the Appellant was not eligible for Medicaid, including HHS provided to the Appellant in [REDACTED].

The Appellant may wish to re-apply for HHS if she meets her Medicaid spend-down or has a change in Medicaid eligibility status.

[REDACTED]
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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 based upon the available information.

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: October 28, 2013

Date Mailed: October 28, 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.