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. 14-010847 HHS
Case No.

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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on .

Appellant did not personally appear. , daughter and POA, appeared as a representative and witness on behalf of Appellant. , chore provider also appeared as a witness.

, Appeals Review Officer, represented the Department of Community Health. , Adult Services Worker (ASW), , , and , Regulation Agent with the Office of Inspector General with the Department of Human Services (DHS) appeared as witnesses on behalf of the Department.

ISSUE

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

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 an year-old female Medicaid beneficiary who has been diagnosed with advanced dementia; decubitis ulcers; pressure sores; anemia/contractures; osteoporosis; glaucoma; and a peg tube. (Exhibit A.70)

2. At all relevant times, Appellant has been a recipient of a HHS grant whose eligibility is determined by an ASW, administered by the DHS.

3. At all relevant times, Appellant's Medicaid scope of coverage was "2F". (Exhibit A.30)

4. Appellant has chosen the 'Medicaid personal care option' which is an

option offered by the DCH/DHS services worker. The actual spend-down/deductible amount is calculated by a different worker-a DHS MA eligibility worker. (Exhibit A; ASM 105; DHS BEM 545).

5. Appellant's spend-down has been $ since , and continuing. (Exhibit A.30) Appellant's HHS grant has been $ since . (Exhibit A.3) Appellant's spend-down has always exceeded Appellant's HHS grant.

6. Appellant's daughter spends additional monies on care for Appellant during hours outside of the HHS approved hours. (Testimony)

7. On , the ASW made a home visit for a review. The ASW did not indicate that there were any changes in HHS but determined that the spend-down amount exceeded the HHS grant.

8. On the ASW issued an Advance Negative Action notice stating that services would be terminated effective as the cost of care did not exceed the Appellant's spend-down (Exhibit A.18)

9. On , the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing. (Exhibit A.6-9)

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 (ASM) 105 (12-1-2013) addresses the Eligibility Criteria for HHS and, regarding that criteria, the manual states in part:

> **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.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

ASM 105, pages 1-2 of 4

Applicable sections of BEM 545 (7-1-2013) to the case here state in part:

EXHIBIT II - MA ELIGIBILITY AND PERSONAL CARE

Clients with excess income who are receiving personal care Home Help Services in their home may be eligible for ongoing MA coverage. MA coverage can be authorized or continued at the client's option provided all conditions in this Exhibit are met.

The client's option to pay a portion of his personal care cost works much the same as paying a patient-pay amount to a hospital or long-term care facility. When a client chooses this option, his services specialist subtracts his excess income from the DHS payment for personal care services. The client is then responsible for paying his excess income amount directly to his personal care provider. This ensures MA does not pay the client's liability.

Discuss this policy option with the client. Advise the client that he will be responsible for paying his excess income to his Home Help Services personal care provider. This cost may include the employer's portion of FICA taxes. The services specialist has information about what portion of the client's excess income is for the provider and what portion is for FICA taxes.

Sometimes personal care costs exceed the maximum amount services will pay. In such cases the client is responsible for the amount services will not pay. If the client chooses the policy option described in this Exhibit, he will be responsible for the amount services will not pay in addition to his excess income. Under these circumstances, this option may not be advantageous to the client.

Conditions of Eligibility

1. The client must meet all nonfinancial eligibility factors and all financial eligibility factors **except** income.

2. The client must have an active Home Help Services case **and** be receiving personal care services in his home. Consider the services case active as soon as the services specialist begins to work with the client.

   The services specialist is responsible for obtaining verification of the need for personal care services and making the Home Help eligibility determination.

3. The amount DHS has or will approve for personal care services must exceed the client's excess income. Contact the services specialist for the following information:

   - The amount DHS has or will approve for personal care services.

- The amount of personal care services required but not approved by DHS.

4. The client must agree to pay his excess income to his provider.

If **all** of the above conditions exist, income eligibility begins the month DHS reduces or will reduce its payment for personal care services by the amount of the client's excess income. The client's excess income becomes his **personal care co-payment.**

Within two working days of determining the client is eligible under this option, notify the services specialist in writing of the MA effective date and the amount of the client's personal care co-payment.SSI-related LOA2 software generates a memo along with the client notice.

Income eligibility does not exist if **any** of the above conditions are not met. Return to the procedure that sent you to this Exhibit.

BEM 545, pages 22-24 of 31

At the administrative hearing here, the testimony for this very lengthy hearing became very confusing and convoluted at times. This ALJ believes that this was so primarily due to the fact that the State of Michigan allows individuals with a spend-down and a HHS grant to meet that spend-down in different ways. One way is by the application of acceptable medical bills and 'old bills' (as permitted by policy) toward the monthly spend-down amount. (See applicable policy and procedure in BEM and BAM)

Another option to meet the spend-down is used in situations where a recipient is allowed to meet the deductible by applying the amount of the HHS grant up to the deductible amount. This is called the personal care option. Personal care option policy is found in ASM 105 and BEMN 545. This option is only available where the HHS grant exceeds the deductible amount. There is no option to use the personal care option if the HHS grant does not exceed the deductible as the recipient would not have Medicaid (as the spend-down would not have been met), and, even if active, there would be no excess for Medicaid to pay. In order for a recipient to have eligibility, a recipient must first pay the deductible; then the excess is paid by Medicaid.

In short, the formula is simple: the deductible portion is paid out of pocket by the recipient of HHS; the remainder, or excess, and only the excess, is paid by Medicaid. Thus, there is no eligibility unless the HHS grant exceeds the deductible. In addition, there is no reason to choose this option if the HHS grant does not exceed the deductible. Policy found in BEM 545 recognizes this by noting that where the HHS grant does not exceed the deductible, THIS OPTION MAY NOT BE ADVANTAGEOUS TO THE CLIENT. There would be no benefit-as is the case here.

Here, Appellant chose the personal care option, and has evidentially for a number of years. (See Exhibit A.24) Appellant did not dispute this choice. However, at hearing, Appellant argued for the application of medical bills when at no time did her HHS grant exceed the spend-down. While there may be situations of overlap as to the application of old bills to meet the deductible thereby triggering HHS grant eligibility, policy is clear-the personal care option is not available unless the HHS grant exceeds the spend-down. (ASM and BEM) At no time in this case did Appellant's HHS grant exceed the deductible. Under ASM and BEM, Appellant has no eligibility for the personal care option. The Department was required to close Appellant's HHS case where it was open under the personal care option where the facts do not show eligibility, and, this ALJ must uphold the Department's closure.

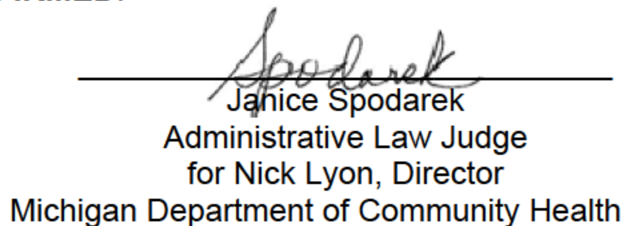
Appellant raised a number of issues over which this ALJ has no jurisdiction: regarding the conduct of a state employee, reviewing Appellant's records relating back years, and issues regarding her employment with the State of Michigan. Appellant also raised issues regarding eligibility determinations made by DHS such as her F2 status, and the potential application of medical bills and 'old bills'-regarding these Medicaid eligibility determinations, Appellant would need to file a hearing request with the DHS.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

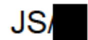
The Department's decision is **AFFIRMED**.



Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed:

Date Mailed:

JS/

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***** 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.