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:

[redacted]

Docket No. 14-008400 HHS
Case No. [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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted].

Appellant personally appeared. [redacted], appeared as a representative and witness on behalf of Appellant.

[redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Worker (ASW), appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly close 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 [redacted] year-old female Medicaid beneficiary who receives MA under the G2S category. Appellant suffered a stroke in [redacted]013. (Exhibit A.15)

2. Appellant's HHS case was opened on or about [redacted] under a scope of "1D" (Exhibit A.14) Appellant was eligible for one month. (Testimony) On [redacted] Appellant's scope was 2H; on [redacted], 2C. (Exhibit A.14)

3. Appellant has chosen the 'Medicaid personal care option' which is an option offered by the DCH/DHS services worker.

4. On [redacted] the ASW conducted an in-home assessment with Appellant and her provider. The ASW notes indicate that the stroke left Appellant partially impaired, not being able to hear, poor vision, difficulty with movements on the left side of her body. (Exhibit A.15)

5. Appellant was approved $[redacted] per month. Appellant's spend-down has always exceeded the grant. During the time period at issue herein, $[redacted] and $[redacted] per month. (Testimony)

6. On [redacted] the Department issued an Advance Negative Action notice stating that Appellant's HHS case will be closed as the cost of care did not exceed the Appellant's spend-down and Appellant did not meet her spend-down. (Exhibit A.5)

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing. (Exhibit A.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.

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

Here, there is no dispute that Appellant needs assistance with ADLs and IADLs. The issue here is whether Appellant meets non-medical criteria, specifically, the personal care option.

As noted above, in order to meet the personal care option an individual must has a HHS grant that exceeds the amount of the spend-down. Otherwise, the personal care option serves no purpose.

At the administrative hearing here, the Appellant stipulated that she has not met her spend-down, and cannot afford to meet her spend-down. Presumable, the failure of Appellant to be able to meet her spend-down would happen whether or not Appellant had chosen the personal care option or application of old bills. In either case, there is no evidence herein that Appellant had active MA-which would not open for Appellant unless or until she meets her spend-down.

The 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. Once again, there is no eligibility under the personal care option unless the HHS grant exceeds the deductible. Under the personal care option, the facts here do not show eligibility, and, this ALJ must uphold the Department's closure.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly closed 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: [redacted]

Date Mailed: [redacted]

JS/[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.