

**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. 2014-19438 HHS

██████████

██████████

██████████

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's son and designated power of attorney, appeared and testified on Appellant's behalf. ██████████, Appeals Review Officer, represented the Department of Community Health. ██████████, Adult Services Worker (ASW), testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's request for 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. On ██████████, Appellant was referred for HHS. (Respondent's Exhibit A, page 14).
2. ASW ██████████ was assigned to the case and scheduled a home visit and comprehensive assessment for ██████████ (Testimony of ██████████).
3. On that date, ASW ██████████ arrived outside of Appellant's home, but did not attempt to go in or speak with Appellant. (Testimony of ██████████).

4. She did speak on the telephone with a representative from the agency that would be providing HHS to Appellant. (Testimony of ██████████).
5. That representative indicated that, as of ██████████ Appellant would have a Medicaid deductible/spend-down and that, while the family would be appealing the spend-down determination, it would not be attempting to meet it each month. (Testimony of ██████████).
6. ASW M ██████████ then confirmed through the Department's computer system that Appellant would have a spend-down of ██████████ per month as of ██████████ and she decided to deny the request for HHS. (Testimony of ██████████).
7. On ██████████, the Department sent Appellant written notice that her application for HHS was being denied. (Respondent's Exhibit A, pages 5-6).
8. Regarding the reason for the action, the notice stated:

In order to meet eligibility criteria for the Home Help program you must have active Medicaid. Records show that you are on a Medicaid monthly deductible that has not been met. Should circumstances change you may re-apply at any time.

Respondent's Exhibit A, page 5

9. On ██████████, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Respondent's Exhibit A, pages 4-13).

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 (5-1-2013) addressed the Eligibility Criteria for HHS at the time of the denial in this case and, regarding that criteria, the manual stated 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.

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Here, the Department denied Appellant's application for HHS pursuant to the above policy and on the basis that her Medicaid was inactive because of an unmet Medicaid monthly spend-down. (Respondent's Exhibit A, page).

However, it is undisputed in this case that Appellant's Medicaid was active at the time the Department denied her request. (Respondent's Exhibit A, pages 5, 15; Testimony of ██████████). Accordingly, the Department erred in denying Appellant's request for services at that time.

While the denial was improper given Appellant's scope of Medicaid coverage at the time of the denial, ASW ██████████ also credibly testified that she had been informed by a representative of Appellant's provider agency that Appellant would soon have a spend-down and that, while Appellant would be appealing that determination, she would not be making any attempt to meet it each month. (Testimony of ██████████).

However, even if true, those statements were made by the proposed provider and that provider has no authority to speak for Appellant or essentially withdraw her request for HHS. ASW ██████████ did not speak or assess Appellant at the time, despite the fact that Appellant's Medicaid coverage was active and Appellant had not withdrawn her request for services. Accordingly, even with the information given by the provider, the Department erred in denying Appellant's request for services at that time.

It is undisputed that Appellant did acquire a spend-down subsequent to the denial and continues to have one, but this Administrative Law Judge's jurisdiction is limited to reviewing the Department's decision in light of the information it had at the time it made that decision. Here, for the reasons discussed above, the Department erred in denying Appellant's request given the available information.

Moreover, the mere fact that Appellant has a spend-down does not mean that she cannot get HHS and the Appellant's representative expressed interest in utilizing the Medicaid Personal Care Option described in the above policy.

Whether or not Appellant meets the conditions for that option is not within the scope of this case. With respect to the issue that is in dispute here, *i.e.* the denial of Appellant's request for services, the undersigned Administrative Law Judge finds that the Department erred and that it must reassess Appellant's request for HHS.

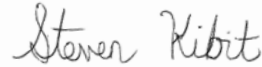
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The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly denied Appellant's request for HHS based in the information available at the time.

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IT IS THEREFORE ORDERED THAT:

The Department's decision is **REVERSED** and it must initiate a reassessment of Appellant's request for HHS.



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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

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.