STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-004438 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.,* upon the Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted] Appellant appeared and testified. [redacted] represented Appellant.

[redacted] Appeals Review Officer, (ARO) represented the Department. [redacted] Adult Services Worker, (ASW), appeared as a witness for the Department. No supervisor appeared at the administrative hearing.

ISSUE

Did the Department properly close 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. Prior to the negative action herein, Appellant had an open HHS case but had not received any payment(s) since [redacted] Appellant is a [redacted] year old female who at the time of the administrative hearing has MA under the "2B" Scope of Coverage. (Exhibit A).

2. Appellant is medically eligible for the HHS program. (Exhibit A).

3. Appellant's last review was [redacted]. (Exhibit A.13).

4. On [redacted] the ASW issued a Notice of Case Termination of Appellant's HHS case on the grounds that Appellant has a "1B" Scope of Coverage and is no longer eligible. (Exhibit A.6).

5. The Department stipulated that the notice was in err and should have stated the Appellant's Scope of Coverage is "2B". (Testimony).

6. No documentary or testimonial evidence was presented explaining what a "1B" or "2B" Scope of Coverage meant. (Testimony). The Department testified that there may not be a "1B" scope of coverage. (Testimony)

7. On [redacted] the Appellant's Request for Hearing was received by the Michigan Administrative hearing System. (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.

The Adult Services Manual (ASM) addresses eligibility for Home Help Services:

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).

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.
>
> *Adult Services Manual (ASM) 105, 11-1-2011 pages 1-2 of 3*

Appellant's medical eligibility is not contested in this case, although Exhibit A.13 seems to indicate that Appellant's last review was completed 2 years ago-on 3/13/13. Rather, the Appellant's HHS case was suspended on the grounds that Appellant no longer met other eligibility requirements pursuant to policy found in ASM 105. This item indicates that in order to have eligibility, a beneficiary must have "Medicaid" eligibility. This policy specifically states that:

> Clients with a scope of coverage 20, 2C or 2B are not eligible for Medicaid until they have met their MA deductible obligation. (ASM 105, page 1 of 4).

At the administrative hearing, it was pointed out that the Department's Advance Negative Action failed to identify Appellant's scope of coverage as 20, 2C, or 2B. Rather, the Advance Negative Action Notice states that Appellant's scope of coverage is "1B" and thus, she is not eligible for the HHS program. At the administrative hearing, the ASW testified that the "1B" was an error and the notice should have stated that Appellant's scope of coverage is "2B."

Having established that the Advance Negative Action Notice was in error, the Department then argued that the notice should have read "2B." However, neither the ASW nor the ARO had any evidence or knowledge as to the definition of a 2B" scope of coverage, (or "1B" for that matter), other than that it likely refers to an individual with a spend-down, as the policy states that an individual with a "…2B scope of coverage is not eligible until they have met their MA deductible obligation." (ASM 105, p 2).

In response, Appellant argued that she does not have a spend-down/deductible. The Department's response was that it was irrelevant as the scope makes Appellant ineligible and it is an eligibility issue. However, contrary to the Department's argument at hearing, the Department's submitted documentary evidence includes a Bridges MA History sheet that indicates that Appellant has a scope of 2B, and, that her spend-down is "[redacted]." Exhibit A.12.

As to the Department's argument that the meaning of a "2B" or a "1B" is irrelevant, this ALJ might normally find the Department's argument persuasive except that the Department's own evidence contradicts its contention that Appellant has a deductible. Exhibit A.12 indicates that beginning [redacted] Appellant's "SD "AMT" was "[redacted]."

In addition, in the past, the Department of Community Health would typically argue that it has no knowledge or information regarding MA eligibility under such facts, as the "Department of Community Health" cannot be held accountable for evidence or information regarding the actions of the Department of Human Services which makes the eligibility determinations for MA. However, effective [redacted], by Order form the Governor of the State of Michigan, there is no longer a DCH and a separate DHS Department, but rather one Department of Health and Human Services. It may be that Appellant has met her deductible; or not. Or it may be that 2B does not refer to a deductible. While the new DHHS cannot be reasonably expected to bear the burden of past DHS actions, here, the decision by the Department is directly impacted by Appellant's scope of coverage, its meaning, and the reason for the denial. On these issues, the Department could not explain the reason for its denial, and essentially argued that the Bridges (a computer) code required closing Appellant's case. A computer cannot substitute for due process.

It would seem that among other reasonable explanations, Appellant may not have a spend-down, or has met her spend-down. In any case, the Department has not met its burden of going forward.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department failed to meet its burden of going forward to establish that Appellant does not have Medicaid financial eligibility, accordingly,

IT IS THEREFORE ORDERED that:

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

The Department is ordered to reassess Appellant's eligibility, and issue a corrected notice. Appellant shall have a right to an administrative hearing for 90 days from the date of the new notice.

Spodarek

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

JS[redacted]

cc: [redacted]

Date Signed: [redacted]

Date Mailed: [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.