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]

Appellant

Docket No. 15-006428 HHS
Case No. [redacted]

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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] Appeals Review Officer, represented the Department. [redacted] Adult Services Worker (ASW) and [redacted], Eligibility Specialist, appeared as witnesses for the Department.

ISSUE

Did the Department properly calculate Appellant's Medicaid deductible for the Home Help Services (HHS) program?

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] Medicaid beneficiary, born [redacted] who has been receiving HHS since at least [redacted]. (Exhibit A, pp 20-21; Testimony)

2. Appellant's Medicaid spend-down, or deductible, for [redacted] and [redacted] was $[redacted] (Exhibit A, p 31; Testimony)

3. On [redacted], Appellant signed a Spend-down Home Help Agreement in which she authorized the Department to use the cost of her HHS payments in the amount of $[redacted] each month to meet her Medicaid spend-down. (Exhibit A, p 25; Testimony).

4. Appellant had agreed at least as far back as [redacted] to use the cost of her HHS to meet her Medicaid spend-down. (Exhibit A, p 26; Testimony)

5. Appellant was paid for her [redacted] on [redacted]. Her [redacted] HHS payment was reduced by $[redacted] reflecting the unmet portion of her Medicaid spend-down for the month. (Exhibit A, p 37; Testimony)

6. Appellant was paid for her [redacted] HHS on [redacted] Her [redacted] HHS payment was reduced by $[redacted] reflecting her Medicaid spend-down for the month. (Exhibit A, p 37; Testimony)

7. On [redacted], Appellant's submitted a Request for Hearing to the Michigan Administrative hearing System in which she questioned the reduction in her HHS payments for the months of [redacted] and [redacted]. (Exhibit 1)

8. Appellant's Request for Hearing was timely because it occurred within 90 days of the issuance of her [redacted] HHS payment on [redacted]. (Exhibit A, p 37; 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.

Adult Services Manual (ASM) 105, 11-1-2013 pages 1-2 of 3

The Department's ASW testified that Appellant's HHS case has been open since [redacted] and is still open today. The Department's ASW testified that Appellant's HHS payments for [redacted] have been processed and her Medicaid spend-down was deducted from each month's payments per Appellant's agreement. The Department's ASW reviewed the Spend-down Home Help Agreement Appellant signed on [redacted] as well as a case note from [redacted] in which Appellant informed her worker at the time that she wished to use her HHS to meet her Medicaid spend-down. The Department's ASW testified that if a client wishes to meet their Medicaid spend-down in another way, such as through the submission of medical bills, the client must inform the Department.

The Department's Eligibility Specialist testified that as an Eligibility Specialist he oversees clients' eligibility and, if a client is using medical bills to meet his or her Medicaid spend-down, he would be responsible for receiving, verifying, and applying those bills. The Department's Eligibility Specialist reviewed the bills Appellant had submitted with her request for hearing and testified that those bills would not have changed the use of her HHS to meet her Medicaid spend-down in [redacted] The Department's Eligibility Specialist indicated that some of those bills had already been applied to prior deductibles and some were not clear on when the services actually occurred. The Department's Eligibility Specialist also indicated that if a client uses medical bills to meet his or her spend-down, bills submitted in excess of the amount of the monthly spend-down cannot be carried over to subsequent months.

Appellant testified that she started to have a carryover on her spend-down starting in [redacted] and those additional amounts were not applied. Appellant testified that she has had three different case workers since the [redacted] and that the first case worker did not properly log in all of the receipts she submitted, so those amounts did not roll over to the next month. Appellant admitted that she was told that bills submitted in excess of the deductible do not carry over, even though another case worker told her to request a hearing. Appellant also testified that she has now switched to an Agency for HHS and they handle the financial aspects of her case too.

Based on the evidence presented, Appellant has failed to prove, by a preponderance of the evidence, that the Department erred in refusing to adjust Appellant's HHS payment for [redacted] Appellant met her spend-down through her HHS payment for the months of [redacted]. If Appellant had submitted medical bills prior to November 2014 that were in excess of the monthly spend-down, those bills would not carry over to the next month. The Department's Eligibility Specialist testified that he instructs beneficiaries to try to meet their monthly deductible exactly on and not over as any overages are not carried over. Therefore, the Department's action was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request to have her November 2014 and December 2014 HHS payments adjusted.

IT IS THEREFORE ORDERED that:

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

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

[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.