STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-008587 HHS

[redacted] [redacted] [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 Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted] [redacted] represented Appellant. [redacted], Appellant's father, was also present on Appellant's behalf. [redacted], Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). [redacted], Adult Services Specialist, testified as a witness for the Department.

ISSUE

Did the Department properly decide to terminate Appellant's Home Help Services?

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 male who had been receiving HHS through the Department, with a total monthly care cost of [redacted] (Exhibit A, pages 14, 23).

2. On [redacted] Appellant received written notice that his Medicaid coverage was ending as of [redacted] Exhibit A, page 7).

3. Appellant appealed that termination of Medicaid coverage. (Exhibit A, page 7).

4. ASW [redacted] is the worker for Appellant's HHS case and, after learning that Appellant's Medicaid coverage was ending, she determined that Appellant's HHS should also be terminated as a HHS client must be eligible for Medicaid and have a scope of coverage of 1F, 2F, 1D, 1K, 1T, or 3G to receive HHS. (Exhibit A, page 24; Testimony of ASW [redacted]).

5. On [redacted] ASW [redacted] sent Appellant written notice that his HHS would be terminated, effective [redacted] because his Medicaid coverage had an end date of [redacted]. (Exhibit A, page 9-12).

6. However, ASW [redacted] also testified that, regardless of the effective date identified in that notice of termination, the Department's computer system would not issue any payments after [redacted] if Appellant's Medicaid coverage ended on that date. (Testimony of ASW [redacted]).

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the termination of HHS. (Exhibit A, page 6).

8. As part of that request, Appellant's representative noted that Appellant received two notices of action with different effective dates and that Appellant's services should remain in place during the pendency of the appeal given the timing of the request for hearing. (Exhibit A, page 6).

9. Appellant's scope of Medicaid coverage subsequently changed to 3G, with an effective date o [redacted] and no end date identified. (Exhibit A, page 21).

10. On [redacted] ASW [redacted] sent Appellant a written Services and Payment Approval Notice providing that HHS have been reinstated, effective [redacted], because, per her review of Appellant's eligibility screen, his Medicaid coverage has been reopened. (Exhibit A, page 13).

11. While the approval notice was mailed out, any HHS payments after [redacted] are still pending ASW [redacted] supervisor's approval. (Exhibit A, page 23; Testimony of ASW [redacted]).

12. However, the Department's representative conceded during the hearing that payments should be approved for at least the time period of [redacted] through [redacted].

13. The Department's representative and other witness also stated that they are not sure that HHS payments should continue beyond [redacted] as they believe Appellant's Medicaid coverage may have ended again on that date. (Testimony of ASW [redacted]

14. ASW [redacted] further testified that, while she has not done yet because of the shifting scopes of coverage and the pending hearing, she will send out another negative action notice if Appellant's Medicaid coverage did end on [redacted]. (Testimony of ASW [redacted]

15. She also noted that, regardless of whether the payments after [redacted] are approved by her supervisor and a new negative action notice has not yet been sent out, the Department's computer system will not issue any payments after [redacted] if Appellant's Medicaid coverage ended on that date. (Testimony of ASW [redacted].

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 statutes, 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.

With respect to eligibility criteria for HHS, Adult Services Manual 105 (4-1-2015) provided in part:

> **GENERAL**
>
> Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened for supportive services to assist the client in applying for Medicaid (MA).
>
> Home help services payments cannot be authorized prior to establishing Medicaid eligibility and completing a face-to-face assessment with the client. Once MA eligibility has been established, the case service methodology must be changed to case management.

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).
- 3G (Healthy Michigan Plan).

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

Here, pursuant to the above policy, the Department decided to terminate Appellant's HHS on the basis that his Medicaid coverage was ending on [redacted]. However, after Appellant's scope of Medicaid coverage subsequently changed to 3G, with an effective date of [redacted] and no end date identified, the Department sent out a Services and Payment Approval Notice providing that Appellant's HHS had been reinstated, with a retroactive effective date of [redacted]. Nevertheless, while that approval notice was issued, any payments after [redacted] appear to be still pending the ASW's supervisor's approval and services may again stop as of [redacted] due to Appellant again losing Medicaid coverage as of that date.

In response, Appellant's representative does not dispute that Appellant Medicaid coverage initially ended as of [redacted] and the undersigned Administrative Law Judge therefore concludes that, based on the information available at the time, the Department properly decided to terminate Appellant's HHS.

Appellant's representative does argue that, given the timing of Appellant's appeals of the termination of Medicaid coverage and the subsequent termination of his HHS, Appellant's HHS should have remained in place while the hearing in this matter was pending. However, while Appellant's representative correctly cites to the applicable Code of Federal Regulations and Adult Services Manual 150, that issue appears to be resolved as the Department is in the process of approving HHS as of [redacted] and, regardless, the undersigned Administrative Law Judge cannot remedy any error at this point given that the termination was proper based on the information available at the time.

The relief Appellant's representative asks for is an order providing that Appellant's HHS and payments for those services should remain in place until the appeals regarding his Medicaid eligibility is resolved. However, this undersigned Administrative Law Judge does not have jurisdiction over Medicaid determinations and is limited to reviewing the action at issue in this case, *i.e.* the termination of HHS. Moreover, while his eligibility clearly affects this case, the issues are separate and involve different workers from the Department. Accordingly, a decision in this action should be issued irrespective of what happens in the other case and, based on the information available to Appellant's Home Help case worker, the termination was proper.

Appellant's current Medicaid status is unclear, but the Department properly terminated his HHS in the past based on the information it had at the time and it appears to be reacting properly to any subsequent developments. His HHS case also remains open and his HHS can be adjusted when appropriate and/or if Appellant does prevail in his Medicaid eligibility case. Moreover, to the extent he disagrees with any future action, Appellant can always request another administrative hearing. Regardless of what happens in the future however, the clear policy and undisputed evidence demonstrate that the termination at issue here was proper and that the Department's action must therefore be affirmed.

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**.

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

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.