STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: March 30, 2016
MAHS Docket No.: 16-000884
16-000885
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

HEARING DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Petitioner's mother/care giver and Authorized Hearings Representative appeared and testified on Petitioner's behalf. [redacted], Appeals Review Officer, represented the Respondent, Michigan Department of Health and Human Services (MDHHS or the Department). [redacted], Adult Services Specialist; and [redacted], Adult Services Specialist/Regulation Agent appeared and testified on behalf of the Department (Respondent).

This hearing is consolidated with Docket # [redacted] HHS as Petitioner filed an identical Request for Hearing on [redacted] and [redacted]. Respondent's Exhibit A pages 1-88 were admitted as evidence.

ISSUE

Did the Department properly determine that Petitioner was not eligible 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. Petitioner was as HHS benefit recipient.

2. Petitioner has been diagnosed with a cerebrovascular accident with right hemiplegia, Lupus, Coronary Artery Disease, Seizure Disorder. She is wheelchair bound. (Respondent's Exhibit A page 64)

3. On [redacted], Petitioner's physician signed a DHS-54A Medical Needs form certifying that Petitioner has a medical need for assistance with all personal care activities. (Respondent's Exhibit A page 70)

4. Petitioner was approved for $[redacted] per month in HHS benefits. (Respondent's Exhibit A page 8)

5. The full amount of HHS was being paid to Petitioner by the Department.

6. On [redacted], the Department sent Petitioner a Healthcare Coverage Determination notice which stated that Petitioner is eligible [redacted] – Ongoing (full coverage). (Respondent's Exhibit A page 42)

7. On [redacted], the Department sent Petitioner a Healthcare Coverage Determination notice which stated that Petitioner is eligible [redacted] – Ongoing (full coverage). (Respondent's Exhibit A page 44)

8. On [redacted], the Department sent Petitioner a Healthcare Coverage Determination notice which stated that Petitioner is eligible [redacted] – Ongoing (full coverage). (Respondent's Exhibit A page 46)

9. On [redacted], the Department sent Petitioner a Healthcare Coverage Determination notice which stated that Petitioner, "…is eligible [redacted] – Ongoing (full coverage). Your deductible amount has changed effective for 1[redacted]. However, you are responsible for paying for these services receive [redacted]." (Respondent's Exhibit A page 48)

10. Petitioner must meet a Medicaid spend-down in the amount of $[redacted] per month before she is eligible for Group 2 Medicaid.

11. It was determined that Petitioner lacked proper Medicaid coverage (2C) to meet eligibility criteria for the home help program. (Respondent's Exhibit A page 22)

12. On [redacted], the caseworker sent Petitioner a DHS – 1212 Advance Negative Action notice, terminating Petitioner's HHS indicating that Petitioner is enrolled in ICO/MI Health Link. This medical coverage does not support the Home Help Program/Independent Living Services. (Respondent's Exhibit A pages 17-18)

13. The caseworker discovered that Petitioner was using her personal care option to meet her spend-down.

14. On [redacted], the Department sent Petitioner a Negative Action letter stating that HHS would be terminated due to an unmet spend-down

effective [redacted].

15. The Adult Services Worker made a referral to the Office of Inspector General for Investigation as the personal care option had not been set up nor verified through the Adult Services Worker as required by policy.

16. On [redacted], the Adult Services Worker sent Petitioner an Advanced Negative Action Notice informing Petitioner that payments would be suspended effective [redacted] due to an investigation by the Officer of Inspector General (OIG). (Respondent's Exhibit A page 7)

17. On [redacted], the caseworker sent Petitioner a DHS – 1210 Services and payment Approval stating that effective [redacted] the personal care option will be used to meet Petitioner's spend-down an/deductible of $[redacted] per month. Her assessed care costs is $[redacted] per month. Petitioner would be eligible for the difference in the amount of $[redacted]6 in HHS benefits. (Respondent's Exhibit A page 29)

18. On [redacted] and [redacted], Petitioner filed a request for a hearing to contest the negative action.

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 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.

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment indicating a

functional limitation of level 3 or greater for at least one activity of daily living (ADL).

- Appropriate Level of Care (LOC) status.

Adult Services Manual (ASM) 105, page 1

The Code of Federal Regulations (CFR) affords a Medicaid beneficiary a right to a fair hearing when the Department takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *42 CFR 438.400.*

Clients with a scope of coverage 20, 2C, or 2B are not eligible for Medicaid until they have met their MA deductible obligation. Policy prevents the use of Medicaid funds to meet a beneficiary's Medicaid spend-down and has clear procedural policy to use this option.

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.

Bridges Eligibility Manual (BEM) 545, page 22-23

Pertinent Department policy dictates:

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.

   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 23-24

In the instant case, Petitioner has requested Home Help Services. Home Health Services were reduced because Petitioner lacks proper Medicaid coverage to meet eligibility criteria. HHS is a Medicaid covered service. As of yet, there has been no denial, reduction, termination, or suspension of a Medicaid covered service. The Petitioner is required to meet the co-pay of her deductible before Medicaid or HHS payments can begin. The department's determination to terminate Petitioner's request

for HHS was in accordance with policy found in the Adult Services Manual. The Department appropriately reduced Petitioner's HHS because Petitioner had no Medicaid eligibility until she has met her Medicaid Spend-down. The Department's actions must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly reduced the Petitioner's HHS case based on the available information.

IT IS THEREFORE ORDERED THAT:

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

LL/[redacted]

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Authorized Hearing Rep. [redacted]

Petitioner [redacted]

DHHS Department Rep. [redacted]

DHHS -Dept Contact [redacted]

DHHS-Location Contact [redacted]

Agency Representative [redacted]