



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

[REDACTED]
MI [REDACTED]

Date Mailed: November 8, 2024
MOAHR Docket No.: 24-010600
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a request for a hearing.

After due notice, a telephone hearing was held on October 24, 2024. Petitioner [REDACTED] appeared and testified on her own behalf, with [REDACTED] Petitioner's son, also testifying as a witness. Allison Pool, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department), with Monica Gibson, Adult Services Worker (ASW), testifying as a witness for the Department.

During the hearing, the Department submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-15. Petitioner did not submit any proposed exhibits.

ISSUE

Did the Department improperly deny payments 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. In 2019, Petitioner was approved for HHS through the Department. (Exhibit A, page 10).
2. At that time, she had a Medicaid scope of coverage of "1F". (Exhibit A, page 12).

3. As of July 31, 2024, Petitioner's scope of coverage changed to "1Y" and she was assigned a Medicaid deductible/spend-down of \$1,087.00 that had to be met each month before her Medicaid coverage became active for that month. (Exhibit A, pages 12-13; Testimony of Petitioner; Testimony of ASW).
4. Petitioner has not met that deductible in any month since it was put into place; and her Medicaid has, therefore, been inactive since July 31, 2024. (Exhibit A, page 13; Testimony of Petitioner; Testimony of ASW).
5. Petitioner's HHS case has remained open following the change in her Medicaid coverage, but no payments for HHS have been made for dates after July 31, 2024. (Exhibit A, page 13; Testimony of Petitioner; Testimony of ASW).
6. On September 23, 2024, MOAHR received a request for hearing filed in this matter with respect to the lack of payments for HHS. (Exhibit A, pages 7-9).

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.

Regarding the eligibility criteria for HHS, Adult Services Manual (ASM) 105 (6-1-2020) states in part:

OVERVIEW

Home Help services are available if the client meets all eligibility requirements. The Adult Services Worker (ASW) may open a Home Help case with supportive services methodology to assist the client in applying for Medicaid (MA), if necessary.

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** the following:

- Medicaid eligibility.
- Appropriate program enrollment type (PET) code.
- 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).

Medicaid Eligibility

The client may be eligible for Medicaid (MA) when either all requirements for Medicaid eligibility have been met, or the Medicaid 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).
- 7W (MI Child).
- 8L (Flint).

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 the Michigan Adult Integrated Management System (MiAIMS) for active services cases.

ASM 105, page 4

As described in the above policy, HHS are only available if a client meets all eligibility requirements, including having a listed scope of Medicaid coverage.

In this case, Petitioner's HHS case has remained open at all times, but no payments have been made for any dates after July 31, 2024, due to a change in Petitioner's Medicaid scope of coverage and her Medicaid being inactive due to an unmet deductible obligation.

In appealing the lack of payments, Petitioner bears the burden of proving by a preponderance of evidence that the Department erred. Moreover, the undersigned ALJ is limited to reviewing the Department's decision in light of the information it had at the time it made the decision.

Given the available information and applicable policies in this case, Petitioner has failed to meet that burden of proof.

As provided above, an individual is only eligible to receive HHS if he or she has active Medicaid coverage and one of the scopes of coverage listed in policy. Here, as credibly found by the Department and undisputed by Petitioner, Petitioner's scope of coverage has been "1Y" and her Medicaid inactive since August 1, 2024, due to an unmet Medicaid deductible. Accordingly, no payments for HHS could be made.

Petitioner has also appealed the determination that she has a Medicaid deductible, but her case is still pending, see MOAHR Docket No. 24-010957; and there has been no reversal of her Medicaid scope of coverage at this time. As discussed during the hearing, if the decision regarding Petitioner's scope of coverage is reversed, then she and her provider may seek retroactive payments for HHS.

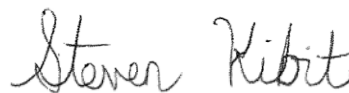
With respect to the decision in this case however, the undersigned ALJ is limited to reviewing the Department's actions here, and based on the undisputed record, its actions were proper and no payments for HHS could be made.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied payments for HHS for Petitioner.

IT IS, THEREFORE, ORDERED that:

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



Steven Kibit
Administrative Law Judge

SK/pe

NOTICE OF APPEAL: Petitioner 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

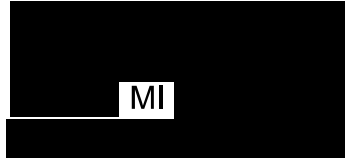
A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

**Via Electronic and
First Class Mail:**

Petitioner



Via Electronic Mail:

Agency Representative

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DHHS Department Contact

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