**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-33303 HHS
Case No. [redacted]

## 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 Appellant's request for a hearing.

After due notice, a hearing was held [redacted] was represented by her daughter, [redacted].

The Department was represented by [redacted]. [redacted], Adult Services Worker appeared as a witness on behalf of the Department.

## ISSUE

Did the Department properly terminate the Appellant's Home Help Services (HHS) payments due to not having full coverage Medicaid?

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant was formerly a full coverage Medicaid beneficiary who participated in the Adult Home Help Services program.

2. The Appellant's Medicaid status changed from full coverage Medicaid to spend-down effective [redacted]. (uncontested)

3. The Appellant's Medicaid deductible each month is [redacted]. The Appellant's expected HHS payment is [redacted] each month she is at home for 30 days. (uncontested)

4. In [redacted], the Appellant was at home for 20 full days and one partial day, the day she was admitted to the hospital. (uncontested)

5. The Department of Human Services determined the Appellant was not eligible for her HHS payment beginning [redacted], because she did not meet her Medicaid spend-down for [redacted] She lacked full coverage Medicaid for any of those months.

6. The Department terminated program eligibility for lack of meeting full coverage Medicaid, effective [redacted]

7. As of the hearing date, Department records reflected the Appellant had not yet met her [redacted] Medicaid deductible.

8. The Appellant received [redacted] days of in-home care in [redacted] (testimony of the Appellant)

9. The Appellant received [redacted] days of in home care for [redacted] (testimony of Department worker)

10. The Appellant is not contesting the denial of [redacted] payment. (testimony of Appellant's representative)

11. The Appellant sought to establish she will have full coverage Medicaid for [redacted] and [redacted] because she has hospital bills to submit. It is not contested that as of the hearing date, Department records did not reflect full coverage Medicaid for [redacted], either through meeting her Medicaid deductible or the Medicaid Personal Care Option.

12. The Appellant was notified that her HHS payments would be terminated due to her lack of full coverage Medicaid.

13. The Appellant requested an administrative hearing contesting the termination of her HHS case on [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 statute, 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.

## ELIGIBILITY FOR HOME HELP SERVICES

Home help services (HHS) are defined as those, which the Agency is paying for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive these services.

### Medicaid/Medical Aid (MA)

Verify the customer's Medicaid/Medical aid status.

The customer may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**
- MA spend-down obligation has been met.

The client must have a scope of coverage of:

- 1F or 2F, **or**
- 1D or 1K (Freedom to work), **or**
- 1T (Healthy Kids Expansion).

Clients with eligibility status of 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple (sic) that daily rate by the number of eligible days.

**Note**: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

**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 the ES.

Conditions of eligibility:

- The client meets all MA eligibility factors except income.
- An ILS services case is active on CIMS (program 9).

- The client is eligible for personal care services.
- The cost of personal care services is **more** than the MA excess income amount.
- The client agrees to pay the MA excess income amount to the home help provider.

Inform the ES of the amount of personal care services (HHS care cost) **and** the amount of personal care required but not approved for HHS payment, i.e., monthly payment does not meet total care needs.

If **all** the above conditions have been met, the client has met MA deductible requirements. The ES will send written notification of the MA effective date and the MA excess income amount.

Upon receipt of the ES notification, enter the client's deductible amount in the **"Resources"** tab of the **"Basic Customer"** module in **ASCAP**.

**Note:** Use the Services Approval Notice (DHS-1210) to notify the client of HHS approval when MA eligibility is met through this option. The notice must inform the client that the HHS payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA excess income amount (deductible) 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.

Notify the ES in writing of any changes in the client's personal care needs. The ES will send written notification of any changes in the monthly MA excess income amount.

MA eligibility under this option **cannot** continue **if:**

- The client no longer needs personal care; **or**
- The cost of personal care becomes **equal to or less than** the MA excess income amount.

**Note:** See Program Eligibility Manual (PEM) 545, Exhibit III, regarding the Medicaid Personal Care Option.

*Adult Services Manual (ASM) 6-1-2007*

Most of the material facts are not in dispute. The Appellant has a monthly Medicaid deductible (spend-down). Normally, she would qualify for the Medicaid Personal Care Option cited above. However, the Appellant's monthly in home care expenses must exceed her Medicaid deductible in order to qualify. The Appellant was hospitalized in [redacted]. Her representative asserts once those bills are submitted, she will have met her deductible. It was not asserted the bills had already been submitted or that the Department had determined she actually met her Medicaid deductible through the submission of hospital bills at hearing. It was not asserted that the Department records indicate she had full coverage Medicaid approved for [redacted] either.

Regarding the Medicaid Personal Care Option, the Appellant's HHS payment amount is potentially higher than her Medicaid deductible, however, her payment amount depends on how many days she is actually at home receiving care. For the months of [redacted] of [redacted] she was admitted to the hospital and did not receive at home care all 30 or 31 days of the month. A daily rate must be determined and then multiplied by the number of eligible days. In [redacted], she was hospitalized after [redacted] days of in home care, on the [redacted]. The Department asserts the day she is hospitalized cannot count towards a day of in home care. The Department will count the day of release from the hospital as a day of in home care.

What constitutes an eligible day is the material issue in dispute. The number of days of care provided for the month of [redacted] is in dispute, although neither party disputes the admission date of hospitalization. For [redacted], the Department witness testified she counted [redacted] days of care, rendering the Appellant ineligible for any amount of HHS payment even if she had the Medicaid Personal Care Option in place prior to hospitalization, because it was less than her Medicaid deductible. The Appellant asserts she had [redacted] days of in home care, thus should have received the home help payment, less the Medicaid deductible. This totals [redacted] for the month. The Appellant contends she received care at home on the day she was admitted to the hospital in [redacted], thus that should count as a day of in home care. She further asserts the care provider log reflects the fact care was provided on the same day as admission into a facility. The Department's witness asserted she could count the day of release from a hospital, but not the day of admission. Because she cannot count the day of hospital admission, she found only [redacted] days of in home care, less than the spend-down amount for the month.

The Appellant cites no Policy supporting her contention that the Department erred by not counting the day of a hospital admission. She has no authority supporting her position of Department error.

Testimony was taken concerning the month of [redacted] It was undisputed the Appellant received less than [redacted] days of in home care. It is an undisputed fact the Appellant's Medicaid deductible was not met in August of 2009.

This ALJ finds the Appellant has not established the Department erred in closing her Home Help Services case. She was not Medicaid eligible. The Appellant must establish actual Medicaid eligibility in order to prevail in her claim her Home Help Services Payments were terminated in error. She has not met her burden of proof.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly terminated the Appellant's HHS payments.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/12/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.