**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. 2010-11864 HHS
Case [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 the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. The Appellant was represented by [redacted], sister and chore provider. [redacted] appeared and testified. [redacted], Appeals Review Officer, represented the Department (DHS). [redacted], Adult Services Worker, and [redacted], Adult Services Supervisor, appeared as witnesses on behalf of the Department.

## ISSUE

Did the Department properly terminate the Appellant's 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 was receiving Home Help Services.

2. The Appellant's Medicaid status changed from full coverage Medicaid to having a deductible effective [redacted]. (Exhibit 1, page 5)

3. The Appellant's Medicaid deductible was [redacted] per month in [redacted], [redacted] per month in [redacted] and changed to [redacted] month effective [redacted]. (Exhibit 1, page 5)

4. The Appellant's Home Help Services case was evaluated and it was determined she was potentially eligible for [redacted] per month in Home Help Services payments. (Exhibit 1, page 13)

5. The Appellant's Medicaid deductible exceeds the amount of HHS payments she is potentially eligible for.

6. On [redacted], the Department issued an Advance Negative Action notice informing the Appellant that her HHS services payments would terminate effective [redacted], due to the change in her Medicaid status. (Exhibit 1, pages 6-8)

7. The Appellant requested an administrative hearing contesting the termination of HHS payments on [redacted] (Exhibit 1, pages 3-4)

## 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 department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.

### Medicaid/Medical Aid (MA)

Verify the client's Medicaid/Medical aid status.

> The client may be eligible for MA under one of the following:
>
> - All requirements for MA have been met, **or**
> - MA deductible 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.
>
> *Adult Services Manual (ASM) 9-1-2008*

The material facts are not in dispute. The Appellant was formerly a full coverage Medicaid beneficiary who was receiving Home Help Services. As of [redacted], the Appellant's MA eligibility changed resulting in a monthly Medicaid deductible (spend-down). The amount of her monthly spend-down, [redacted] per month in [redacted] per month in October [redacted] per month effective [redacted], exceeds the potential HHS payment, [redacted], she would receive from the Department each month.

The Adult Services Worker testified that the Medicaid eligibility determinations are made by the Medicaid eligibility worker, who is also responsible for updating related information, including whether the Appellant met her spend down each month, in the Department's computer system. The Adult Services Worker explained that when the Advance Negative Action Notice was issued on [redacted], the computer system did not indicate that the Appellant met her monthly spend down in any month or that her MA eligibility changed back to full coverage Medicaid. The Adult Services Worker explained that she was therefore unable to continue HHS payments to the Appellant. The Adult Services Worker testified that because the Appellant had not met her spend down for three consecutive months, policy instructs that a Negative Action Notice be sent regarding termination of the HHS case.

However, the Adult Services Worker testified that the computer system was later updated by the Medicaid Eligibility Worker to show that the Appellant did in fact meet her spend down in the months of [redacted]. Accordingly, the Appellant was eligible for HHS for part of each of these months under the above cited Department policy. The submitted

records indicate that the Department has already authorized a prorated HHS payment to the Appellant for the portion of each month she was Medicaid eligible. (Exhibit 1, page 14)

Based upon the updated Medicaid Eligibility information, the Department erred by terminating the Appellant's HHS payments. Policy requires a HHS participant to have full coverage Medicaid or have met the monthly Medicaid deductible in order to be eligible for the HHS program. The Appellant met her spend down for two out of the three consecutive months prior to the termination.

The Appellant may qualify for the HHS program at this time. The Department will have to check the computer system to see if the Appellant has met her spend down for any months since [redacted], to determine ongoing eligibility for the HHS program.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department did not properly terminate the Appellant's HHS payments.

**IT IS THEREFORE ORDERED** that:

The Department's decision is REVERSED. The Department is therefore ordered to check whether the Appellant has met her spend down for any months since [redacted] to determine ongoing eligibility for the HHS program.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/18/2010

***** 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.