STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Appellant
_______________________/

Docket No. 2010-13111HHS

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 . appeared on her own behalf. , Appeals Review Officer, represented the Department (DHS). , Adult Services Worker, appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly suspend 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 . (Testimony)

3. The Appellant's Medicaid deductible was per month effective (Testimony)

4. The Appellant's Home Help Services case was evaluated and it was determined she was potentially eligible for per month in Home Help Services payments. (Exhibit 1, page 9)

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 be suspended effective [redacted], due to the change in her Medicaid status. (Exhibit 1, pages 4-7)

7. The Appellant requested an administrative hearing contesting the suspension of HHS payments on [redacted]. (Exhibit 1, page 3)

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

Finally the Code of Federal Regulation Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

§ 431.211 Advance notice.
The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.

§ 431.213 Exceptions from advance notice.
The agency may mail a notice not later than the date of action if—
(a) The agency has factual information confirming the death of a recipient;
(b) The agency receives a clear written statement signed by a recipient that—
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

> (e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
> (f) A change in the level of medical care is prescribed by the recipient's physician;
> (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or (h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

The material facts are not in dispute. The Appellant was formerly a full coverage Medicaid beneficiary who was receiving Home Help Services. As of , the Appellant's MA eligibility changed resulting in a monthly Medicaid deductible (spend-down). The amount of her monthly spend-down of exceeds the potential HHS payment of she would receive from the Department each month. The Department testified that they when they reviewed this case on they did not receive any confirmation that the Appellant met her monthly spend down amount for or that her MA eligibility changed back to full coverage Medicaid. 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. Therefore, the Appellant did not qualify for the HHS program in and the suspension of her HHS payments was appropriate.

It is also undisputed that the Department failed to give the Appellant the required advance notice of this negative action. The worker testified that she had been out on a medical leave and did not discover the , Appellant's change in Medicaid eligibility until . The , Advance Negative Action Notice clearly failed to provide the Appellant with advance notice that her HHS payments would be suspended effective . However, this error does not change the outcome of this case. This ALJ does not have constitutional or equitable powers and therefore lacks the requisite authority to order the Department to pay for HHS services in , when the Appellant was not eligible for this program.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc:

Date Mailed: 2/19/2010

***** 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.