STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Appellant
________________________/

Docket No. 2010-13794 HHS

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 . , sister, appeared on the Appellant's 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 terminate the Appellant's Home Help Services case 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. On , the Adult Services Worker conducted an initial case assessment for the Appellant's recent Home Help Services application. (Exhibit 1, page 8)

2. The worker discovered that the Appellant was not a full coverage Medicaid beneficiary and that she had a monthly deductible amount of . There was also evidence of significant medical bills that were going to be submitted to the Medicaid eligibility worker. (Exhibit 1, page 8)

3. The submitted Medicaid eligibility history for the Appellant reflects a deductible effective . (Exhibit 1, page 14)

4. The Appellant's Medicaid deductible was per month according to an certification. (Exhibit 1, page 16)

5. 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)

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

7. The Adult Services Worker never received confirmation from the Appellant's Medicaid eligibility worker that she had met her monthly spend down amount or that her Medicaid eligibility changed to full coverage Medicaid. (Testimony)

8. On , the Department issued an Advance Negative Action Notice informing the Appellant that her HHS was would be terminated due to the Medicaid spend down. (Exhibit 1, pages 5-7)

9. A request for an administrative hearing contesting the termination of HHS payments was received on . However, a request signed by the Appellant was not received until . (Exhibit 1, pages 3-5)

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) 363, 9-1-2008 page 7 of 24.

The material facts are not in dispute. At the time of the initial assessment in , the Appellant was not a full coverage Medicaid beneficiary as she had a monthly Medicaid deductible (spend-down) in the amount o (Exhibit 1, page 8) The Adult Service Worker completed the initial assessment and determined the Appellant was potentially eligible for per month in Home Help Services (HHS) payments. (Exhibit 1, page 9) The evidence shows that the monthly deductible amount increased to with the certification. (Exhibit 1, page 16) The Appellant's monthly spend down amount exceeds the potential HHS payment; she would receive from the Department each month.

The Appellant's representative testified that she disagrees with the denial of Home Help Services because of the Appellant's limited means. The Appellant's representative explained that the Appellant has been paying what she can for home care services out of pocket but can not really afford to due to limited resources.

The Appellant's representative also had several questions regarding the Medicaid Spend down calculation. However, this ALJ does not have jurisdiction over Medicaid eligibility determinations, such as spend down calculations. Based on the Adult Service Worker's testimony of spend down amounts as far back as it appears that the Appellant has been on a spend down for quite some time. The Appellant's representative was advised to discuss

her questions regarding the spend sown calculation with the Appellant's Medicaid eligibility worker and that she could file a separate hearing request with the Department of Human Services if she disagrees with the Medicaid eligibility determination.

While this ALJ understands that the Appellant's resources to pay for home care services are limited, Department policy in this area is clear. 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 Department worker testified that he made attempts to contact the Appellant's Medicaid eligibility worker to see if the Appellant met her monthly deductible amount due to the significant medical bills observed at the [redacted] home visit. The Adult Services worker testified that he never received a response from the Medicaid eligibility worker nor any other confirmation that the Appellant met her monthly spend down amount or that her MA eligibility changed to full coverage Medicaid. Therefore, the Appellant did not qualify for the HHS program and the worker terminated the Appellant's HHS case.

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 case based upon the available information.

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: 3/2/2010

***** 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.