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

Docket No. 2010-14388 HHS
Case No. [redacted]

[redacted],

Appellant
_____/

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] son, appeared on the Appellant's behalf. [redacted] and testified. [redacted], represented the Department (DHS). [redacted], appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services 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 (HHS). (Testimony)

2. In [redacted] (ASW) discovered that the Appellant's Medicaid status was going to change from full coverage Medicaid to having a deductible effective [redacted] (Testimony)

3. The Appellant's Medicaid deductible was [redacted] per month. (Testimony)

4. The Appellant had been receiving [redacted] per month in HHS payments. (Exhibit 1, page 9)

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

6. On [redacted], the ASW 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. A request for an administrative hearing contesting the termination of HHS payments was received on [redacted]. (Exhibit 1, page 3) A second request for hearing was received on [redacted]. (Exhibit 2)

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

Policy requires a Home Help Services (HHS) participant to have full coverage Medicaid or have met the monthly Medicaid deductible in order to be eligible for the HHS program. The material facts are not in dispute. The Appellant was formerly a full coverage Medicaid beneficiary who was receiving HHS payments. 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] exceeds the potential HHS payment, [redacted], she would receive from the Department each month. Therefore, the Appellant no longer qualified for the HHS program effective [redacted]

The Adult Services Worker (ASW) testified that on [redacted] she received additional information from the Appellant's doctor's office, which led to an increase in her monthly HHS payment to [redacted]. The ASW stated she then notified the Appellant's Medicaid eligibility worker that the Appellant's potential monthly HHS grant now exceeds her monthly Medicaid deductible obligation. The ASW testified that the eligibility worker has updated the Appellant's Medicaid eligibility status on the Department's computer system effective [redacted], which allowed the ASW to re-open the Appellant's HHS case.

The ASW explained that the Appellant is still responsible for the monthly Medicaid deductible obligation, and therefore her HHS monthly payment may be reduced. For example, in a month where the Appellant does not have any medical bills that can be considered toward her deductible, she would only receive a HHS payment of [redacted]. ([redacted] potential payment minus [redacted] deductible obligation) In a month where the Appellant has $1[redacted] in medical bills that can be considered toward her deductible, she would receive a HHS payment of [redacted] for the month. If the Appellant had medical bills that met or exceeded her Medicaid deductible obligation for the month, she would receive the full HHS potential payment of [redacted]

The Department established that at the time the Advance Negative Action was issued, [redacted], the determination to terminate HHS payments was appropriate. The Appellant did not become eligible for HHS payments again until [redacted], when her potential HHS payment was increased. The termination of HHS payments from [redacted] to [redacted], is upheld.

The Appellant's representative also contests that the HHS payments did not continue pending this Hearing Decision. The Hearing Rights page from the [redacted], notice states:

> You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action.
>
> If you continue to receive benefits because you requested a fair hearing, you may be required to repay the benefits. This may occur if:
>
> - The proposed termination or denial of benefits is upheld in the hearing decision.
> - You withdraw your hearing request.
> - You or the person you asked to represent you does not attend the hearing.
>
> (Exhibit 4, page 2)

In the present case, the Appellant did file the initial hearing request prior to the [redacted], effective date indicated on the Advance Negative Action Notice. (Exhibit 1, page 3, and Exhibit 2, page 1) Accordingly, the HHS payments should have continued pending this hearing decision. The ASW testified that she attempted to reinstate the Appellant's HHS payments; however, the Department's computer system would not allow this because the Medicaid deductible was in effect and had not been met. (See also Exhibit 1, page 11)

However, if the Department had been able to reinstate the Appellant's HHS payments pending this hearing decision, she would now be obligated to re-pay the benefits as the proposed termination is being upheld. Therefore, this ALJ can not order the Department to retroactively issue payment for the months the hearing request was pending.

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.

_____

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

[redacted]
Docket No. 2010-14388 HHS
Decision and Order

cc: [redacted]

Date Mailed: 4/2/2010

***** 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.