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

[redacted]

Appellant
_____/

Docket No. 2010-16661 HHS
[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]. [redacted] appeared on her own behalf. [redacted], Case Manager [redacted] Adult Mental Health, appeared as a witness for the Appellant. [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 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. The Appellant is a full coverage Medicaid beneficiary, who was receiving Home Help Services. (Exhibit 1, pages 7-11)

2. The submitted Medicaid eligibility history shows that the Appellant's Medicaid eligibility scope of coverage changed from 1F to 1P effective [redacted]. (Exhibit 1, page 11)

3. On [redacted], the Department issued an Advance Negative Action Notice informing the Appellant that her HHS was would terminate effective [redacted] because she did not have Medicaid eligibility as of [redacted]. (Exhibit 1, pages 4-6)

4. The Appellant's request for an administrative hearing contesting the termination of HHS payments was received 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) 363, 9-1-2008 page 7 of 24.*

Department policy requires a Home Help Services recipient to have full coverage Medicaid with a qualifying scope of coverage. The Appellant's Medicaid eligibility history shows that as of [redacted], her scope of coverage changed from 1F to 1P. The submitted excerpts from the Medicaid Provider Manual, Beneficiary Eligibility Section, [redacted] indicate that a scope code of 1 indicates Medicaid, the coverage code of F indicates full Medicaid coverage and the coverage code of P indicates Transitional Medical Assistance-Plus (TMA-Plus) which is also full Medicaid coverage. (Exhibit 1, pages 13-14) While the Appellant is still a full coverage Medicaid beneficiary, the Appellant no longer had a qualifying scope of coverage for Home Help Services due to the change in Medicaid coverage to TMA-Plus. The scope of coverage for the TMP-Plus Medicaid, 1P, is not one of the qualifying scope of coverage codes listed in the above cited Adult Services Manual Policy.

The Appellant disagrees with the termination and testified that she was never informed that if she switched to the TMA-Plus Medicaid coverage she would no longer be eligible for Home Help Services. The Appellant also noted that at the [redacted], home visit with the Adult Services Worker, she was told her provider would be paid.

The Adult Services worker explained that at the time of the [redacted], home visit, there was a problem with the Department's computer system and while the Appellant's Medicaid coverage showed a spend down, this appeared to be an error the was being corrected by the Medicaid Eligibility worker. (See also Exhibit 1, page 7) The Adult Services Worker is not involved in the Medicaid eligibility determination process and can only rely on the information available on the Department's computer system and from the Medicaid Eligibility worker. Accordingly at the time of the home visit, the Adult Services Worker believed the Appellant would still qualify for Home Help Services.

The Appellant's witness testified that [redacted] also had difficulty confirming that Appellant's Medicaid eligibility during that timeframe. The Appellant's witness testified that initially the Appellant had regular Medicaid, then the system showed a spend down beginning in October and eventually the Appellant's coverage changed to the TMA-Plus Medicaid coverage. The Medicaid Eligibility History shows that the change to the TMA-Plus scope of coverage was made on [redacted] and made retroactively effective [redacted].

While the evidence shows that there was a period of several months where the Appellant's Medicaid Eligibility was unclear as changes occurred, the evidence supports the Department's determination to terminate services. Effective [redacted] the Appellant's Medicaid coverage changed to TMA-Plus which does not qualify her for Home Help Services.

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: [redacted]

Date Mailed: 4/15/2010

***** 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.