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:

[redacted]

Appellant
_____/

Docket No. 2010-30682 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 on [redacted]. The Appellant was present. He was represented by his mother, [redacted]. The Department was represented by Appeals Review Officer, [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 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).

2. The Appellant's Medicaid status changed from full-coverage Medicaid to spend-down effective [redacted] (Exhibit 1, page 10)

3. The Appellant's Medicaid deductible is [redacted] per month. (Exhibit 1, page 9)

4. The Appellant's HHS needs have been assessed at [redacted] per month in HHS payments. (Exhibit 1, page 13)

5. The Appellant's co-pay exceeds the amount of HHS he is potentially eligible for.

6. The Appellant was notified that his HHS benefits would be terminated effective [redacted], due to his lack of full-coverage Medicaid and his payment not meeting or exceeding his deductible amount. (Exhibit 1, pages 6-8)

7. The Department received an unsigned request for an administrative hearing to contest the termination of his HHS benefits on [redacted]. A signed request 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.
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> *Adult Services Manual (ASM) 363, 9-1-2008 page 7 of 24.*

The material facts of this case are not in dispute. The Appellant has a monthly Medicaid deductible (spend-down) of [redacted]. The Appellant was assessed at [redacted] per month in HHS payments for grooming, medications, housework, shopping, and meal preparation. Therefore, the amount of Appellant's monthly spend-down exceeds any potential HHS payments he would receive from the Department each month. Policy requires a HHS participant to have full-coverage Medicaid or have an HHS payment that exceeds his Medicaid deductible in order to be eligible for the HHS program. Accordingly, he did not qualify for the program at the time the termination notice was issued.

However, there was testimony that the Appellant had met his monthly spend-down by submitting other bills for services for parts of the months of [redacted], and [redacted], and that prorated payments have been made for the portion of those months that he was eligible for HHS payments. Further, it appears likely that at least partial eligibility will continue into the future.

Based on the eligibility information that the worker had at the time the termination notice was issued—that the Appellant was not meeting his monthly spend-down—the action was appropriate. However, given the new information regarding the Appellant's potential eligibility for at least partial months, termination is no longer appropriate. Rather, if there are periods of ineligibility because the Appellant has not met his monthly spend-down, suspension for those periods would be the more appropriate way to handle this matter.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly terminated the Appellant's HHS benefits.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department shall continue to monitor the Appellant's eligibility and approve HHS monthly payments, either partial or full, depending on the Appellant's eligibility status.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/9/2010

***** 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.