STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[REDACTED]

Appellant
_______________________/

Docket No. 2010-3931 HHS
Case No [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 his own behalf. [REDACTED] Appeals Review Officer, represented the Department (DHS). [REDACTED], Adult Services Specialist and [REDACTED] Services Program Manger, appeared as witnesses on behalf of the Department.

ISSUE

Did the Department properly terminate 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 [REDACTED]. (Exhibit 1, page 6)
3. The Appellant's Medicaid deductible is [REDACTED] per month. (Exhibit 1, page 6)
4. The Appellant's Home Help Services case was evaluated and it was determined he was potentially eligible for [REDACTED] per month in Home Help Services payments. (Exhibit 1, page 10)
5. The Appellant's Medicaid deductible exceeds the amount of HHS payments he is potentially eligible for.

6. The Appellant was notified by letters sent by the Department on , that his HHS services payments were suspended due to the lack of full coverage Medicaid, not meeting or exceeding his deductible amount and not being able to meet for the review appointment. (Exhibit 1 pages 4-5)

7. The Appellant requested an administrative hearing contesting the termination of HHS payments on .

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

The material facts are not in dispute. The Appellant was formerly a full coverage Medicaid beneficiary who was receiving Home Help Services. As of [redacted], the Appellant's MA eligibility changed resulting in a monthly Medicaid deductible (spend-down). The amount of his monthly spend-down, [redacted], exceeds the potential HHS payment, [redacted], he would receive from the Department each month. The department testified that they have not received any confirmation that the Appellant has met his monthly spend down amount or that his MA eligibility changed back to full coverage Medicaid. Therefore, the Appellant does not qualify for the HHS program at this time. 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.

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.

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

cc:

Date Mailed: 12/29/2009

*** **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.