STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2011-30133 HHS
Case No. [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 on [redacted]. Attorney [redacted] appeared on Appellant's behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], General Services Program Manager, and [redacted] Adult Services Specialist, from the [redacted] DHS Office appeared as witnesses for the Department.

ISSUE

Did the Department properly prorate the Appellant's Home Help Services (HHS) payment to the day of the month Appellant met his spend-down, beginning in [redacted]?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old man who has been diagnosed by a physician with cerebral palsy, bilateral hearing impairment, and a medical history of decubiti on his buttocks. A physician has also diagnosed Appellant as a non-verbal communicator. (Exhibit 1, page 6).

2. Appellant's brother is his legal guardian. (Exhibit 1, page 8).

3. Appellant had been receiving 116 hours and 23 minutes of HHS per month, with a care cost of [redacted] per month. (Exhibit 1, page 10).

4. On [redacted] sent an Advance Negative Action Notice providing that, effective [redacted], Appellant's HHS payments would be suspended until a spend-down/deductible of [redacted] was met each

month. (Exhibit 1, pages 11-14; Testimony of Swanson).

5. Following [redacted], HHS payments have been authorized for the time periods in which Appellant's Medicaid was active each month. (Testimony of [redacted]).

6. On [redacted], the Department received Appellant's Request for Hearing, signed by Appellant's guardian. In that request, Appellant's guardian stated that DHS erred in classifying his brother and in determining Appellant's Medicaid eligibility. (Exhibit 1, pages 4-5). Appellant later became represented by an attorney.

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 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.

Adult Services Manual 362 (12-1-07) (hereinafter "ASM 362") and Adult Services Manual 363 (9-1-08) (hereinafter "ASM 363") address the issue of eligibility for HHS:

> **Home Help Services (HHS)**
>
> **Payment** related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:
>
> - The client must be eligible for Medicaid.
> - Have a scope of coverage of:
>   - 1F or 2F,
>   - 1D or 1K, (Freedom to Work), **or**
>   - 1T (Healthy Kids Expansion).
> - The client must have a need for service, based on

- Client choice, **and**
- Comprehensive Assessment (DHS-324) indicating
  a functional limitation of level 3 or greater in an ADL
  or IADL.

- Medical Needs (DHS-54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:

  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

(ASM 362, pages 1-2 of 5)

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.

(ASM 363, page 7 of 24)

The Department must implement its programs in accordance with its policies. The Department policy listed immediately above mandates that a person with a scope of coverage 20 must meet the monthly spend-down to activate his Medicaid eligibility in order to receive payment for HHS and the Department cannot authorize HHS payment prior to the MA eligibility date.

Here, the material facts are not in dispute. Appellant has had a monthly Medicaid deductible (spend-down) since [redacted]. (Exhibit 1, pages 11-14; Testimony of Swanson). Adult Services Specialist [redacted] testified that, since Appellant's Medicaid was switched to a spend-down, payments have only been authorized for the time periods in which Appellant's Medicaid was active each month, *i.e.* after Appellant met his spend-down obligation. (Testimony of [redacted]). Appellant does not dispute the calculation and proration of the specific HHS payments Appellant has received.

Appellant does disagree with the spend down/deductible determination itself and its effect on his HHS payments. However, as noted during the hearing, this Administrative Law Judge has no jurisdiction over the Medicaid eligibility determinations. Appellant's attorney has been advised to file a hearing request in the appropriate forum so that a separate hearing can be scheduled to address the Medicaid spend down/deductible determination with the Department of Human Services.

With respect to the issue present here, the Department's decision must be affirmed. The Department cannot authorize HHS payment prior to the Medicaid eligibility date and it has not done so here. However, once Appellant met his monthly spend-down and activated his Medicaid eligibility, it authorized prorated HHS payments.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that, since [redacted], the Department has properly prorated the Appellant's Home Help Services payment to the day of the month Appellant met his spend-down.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/11/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.