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

IN THE MATTER OF:

Docket No. 2011-42099 HHS
Case No. 1053504575

[REDACTED],

Appellant.
_________________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [REDACTED]. Appellant appeared and testified on her own behalf. [REDACTED], Appellant's chore provider, also testified on Appellant's behalf. [REDACTED], Appeals Review Officer, represented the Department of Community Health. [REDACTED], Adult Services Specialist, and [REDACTED], Medicaid Eligibility Specialist, from the [REDACTED] County DHS Office appeared as witnesses for the Department.

ISSUE

Did the Department properly deny Appellant's application for Home Help Services (HHS)?

FINDINGS OF FACT

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

1. In [REDACTED], Appellant applied for HHS. (Exhibit 1, page 11).

2. As part of the application process, Adult Services Specialist [REDACTED] determined that Appellant would require 19 hours of assistance per month. (Testimony of [REDACTED]; Exhibit 1, pages 6, 9).

3. At the time of the application, Appellant had a monthly deductible/spend-down of $[REDACTED] that must be met before her Medicaid would become active. (Exhibit 1, page 12).

4. Appellant has never met that deductible/spend-down and she has never been eligible for Medicaid. (Testimony of [REDACTED]).

5. On , the Department sent Appellant an Adequate Negative Action Notice providing that Appellant's application for HHS is denied as Appellant's monthly care needs would be less than her monthly spend-down. (Exhibit 1, pages 6-7).

6. On , the Department received Appellant's Request for Hearing. In that request, Appellant noted that she was going to be admitted to the hospital soon and has significant medical needs. (Exhibit 1, page 4).

7. On , the Department sent Appellant a letter indicating that her spend-down had been met for the period of to , . (Testimony of y, Testimony of).

8. That th letter was sent in error and Appellant never met her monthly spend-down at any time. (Testimony of ; Testimony of).

9. While the letter was sent in error, the Department will honor its contents and retroactively award HHS for the period between and . (Testimony of). The amount of HHS payments will be based on the assessment performed by Adult Services Specialist . (Testimony of).

10. On , the Department sent Appellant a letter indicating that her spend-down would resume . (Testimony of).

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 must be eligible for Medicaid with a scope of coverage 1F or 2F; or the monthly spend-down must be met, in order to receive HHS.

Here, the material facts are not in dispute. Prior to and during the time her application was pending, Appellant has always had a monthly deductible that must be met before her Medicaid becomes active and she has never met that monthly deductible. Moreover, Appellant's spend-down could not be met through her HHS because her monthly care needs would be less than her monthly spend-down. The Department provided credible evidence that the Appellant's Medicaid was not active at the time of the notice of denial and her Medicaid must be active in order to receive HHS. Accordingly, the Department's denial must be affirmed.

It is also undisputed that, subsequent to the denial in this case, the Department erroneously sent out a letter indicating that Appellant's spend-down had been met for the period of [redacted] to [redacted]. The Department has determined that it will honor the contents of that letter and retroactively award HHS for the period between

and . Nevertheless, based on the information available at time, its earlier decision to deny HHS is affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's application for Home Help Services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 9/2/2011

***** 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.