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:

Docket No. 2011-4892 HHS
Case No. 86251114

[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 [redacted].

The Appellant represented himself at hearing. His chore provider was present as a witness on his behalf.

The Department was represented by [redacted]. [redacted], was present on behalf of the Department. [redacted], was present 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 and Home Help Services recipient.

2. The Appellant has received Home Help Services payment assistance in the amount of $[redacted] per month.

3. The Appellant has a Medicaid deductable (formerly spend down) of $[redacted] per month.

4. Past Department error resulted in the Appellant's covered medical bills being used to satisfy his monthly spend down, resulting in the Adult Services Worker being notified that he had full Medicaid coverage.

5. The Appellant's Medicaid status changed from full coverage Medicaid to Medicaid deductible following implementation of policy prohibiting the [redacted] from applying medical bills paid by third party payers towards a Medicaid deductable (formerly spend down).

6. The Appellant is not currently eligible for full coverage Medicaid.

7. On [redacted], the Appellant was notified his Home Help Services payment would be reduced to [redacted] dollars effective [redacted], due to Medicaid ineligibility.

8. The Appellant requested an administrative hearing contesting the denial of his HHS services on [redacted].

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 Agency is paying for through Title XIX (Medicaid) funds. The customer 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.*

The material facts are not in dispute. The Appellant has a monthly Medicaid deductible (spend down). The amount of his monthly spend down exceeds the potential HHS payments he would receive from the Department each month, thus does not become eligible by satisfying the deductible with his HHS payment assistance. Additionally, only Department error in calculating how his monthly spend down could be satisfied rendered him putatively eligible in the past. The Department is entitled to remedy its past mistakes, and seeks to do so by notifying the Appellant that he can no longer apply Medicare covered medical expenses towards his Medicaid deductable. (BEM 545, page 14). The Department's action is supported by policy. It is an undisputed material fact that the Appellant does not have full coverage Medicaid, thus he does not qualify for the program at this time. Policy requires a HHS participant to have full coverage Medicaid or have a HHS payment that exceeds his 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 Home Help Services payments.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/16/2010

***** 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.