STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2011-6182 HHS
Case No. 49587542

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] the Appellant, appeared on his own behalf. [redacted] appeared as a witness for the Appellant. [redacted] represented the Department. [redacted] and [redacted] appeared as witnesses on behalf of the Department.

ISSUE

Did the Department properly deny the Appellant's Home Help Services application?

FINDINGS OF FACT

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

1. On [redacted] the Department received a referral for the Appellant to the Home Help Services program. ([redacted] Testimony)

2. At the time of the referral, there was a coding error regarding the Appellant's Medicaid eligibility status in the computer system. The system incorrectly showed a 1F Scope of Coverage Code, indicating full Medicaid coverage, due to an incorrect 22 Level of Care Code, reflecting waiver enrollment. Without this incorrect Level of Care Code, the Appellant's scope of coverage code would have indicated a large monthly spend

down/deductible that must be met each month prior to Medicaid eligibility. (Exhibit 1 and [redacted] Testimony)

3. Department policy requires Medicaid eligibility in order to receive Home Help Services. (Adult Services Manual (ASM) 362, December 1, 2007, pages1-2 of 5, and Adult Services Manual (ASM) 363, September 1, 2008, page 7 of 24)

4. On [redacted] the Department issued an Adequate Negative Action Notice informing the Appellant that his Home Help Services application was denied. (Exhibit 1, pages 4-6)

5. The coding error has since been corrected, reflecting a Medicaid spend down/deductible for the Appellant's Medicaid eligibility status. (Exhibit 2 and [redacted] Testimony)

6. The Appellant is not able to meet his spend down/deductible obligation each month. (Appellant Testimony)

7. The Appellant's request for an administrative hearing contesting the Home Help Services denial 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.

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.

Adult Services Manual (ASM) 362, 12-1-2007 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.
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> *Adult Services Manual (ASM) 363, 9-1-2008 page 7 of 24.*

Department policy requires a Home Help Services participant to have full coverage Medicaid with a qualifying scope of coverage in order to be eligible for the HHS program. The Appellant's scope of coverage incorrectly indicated full Medicaid coverage (1F) at the time he was referred to the HHS program. This was due to a coding error regarding his Level of Care code (22), which incorrectly indicated the Appellant was enrolled in the waiver program. The Department contacted the waiver agencies to confirm that the Appellant was not enrolled in the waiver program, then the Medicaid eligibility worker to have the coding error corrected. Without waiver enrollment, the Appellant had a large monthly spend down/deductible that would have to be met each month before he would become eligible for Medicaid coverage for that month. (Exhibit 1, and [redacted] Testimony) The Level of Care coding error has since been corrected. (Exhibit 2)

The Appellant disagrees with the spend down/deductible determination and the denial of his HHS application. (Appellant Testimony) As noted during the hearing, this ALJ has no jurisdiction over the Medicaid eligibility determinations. The Appellant's hearing request has been forwarded so that a separate hearing can be scheduled to address the Medicaid spend down/deductible determination with the Department of Human Services.

The Appellant also testified that he has never been on the waiver program and that he can not meet his monthly spend down/deductible obligation. Regarding the HHS program, the Appellant indicated that he needs assistance in his home. He stated that he has heart failure and kidney failure. The Appellant explained that his doctor says he

will have to have a nurse come to his home for the rest of his life. (Appellant Testimony)

The Appellant's need for Home Help Services is not at issue in this case. Rather, his application for the HHS program was denied due to his Medicaid eligibility status. 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. The qualifying scope of coverage code (1F) showing at the time of the referral to the HHS program was incorrect, and the Department properly sought to correct the coding error. The evidence supports the Department's determination to deny the Appellant's application because once the coding error was corrected, the Appellant had a large monthly spend down/deductible that must be met before he could become eligible for Medicaid each month. There was no evidence presented indicating that the Appellant had met his spend down/deductible obligation each month to become Medicaid eligible. Rather, the Appellant testified that he can not meet his large spend down/deductible each month. Accordingly, he was not 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 denied the Appellant's HHS application.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 2/22/2011

***** 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.