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. 2012-27827 HHS

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 i, Attorney, The , represented the Appellant. the Appellant, was present. , mother and Guardian, appeared as a witness for the Appellant. uakpor, Appeals Review Officer, represented the Department. Adult Services Worker ("ASW"), and , Adult Services Supervisor, appeared as a witness for the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services ("HHS") payments?

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 receiving HHS.

2. From through , the Appellant was authorized for HHS with a total monthly care cost of . (Exhibit 2, page 2)

3. The Appellant's Medicaid status changed from full coverage Medicaid to having a deductible, or spend down, effective (Exhibit 1, page 8)

4. The Appellant's Medicaid spend down was and changed to effective (Exhibit 1, page 8)

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

6. The Appellant's Medicaid spend down exceeded the total monthly care cost of HHS he was potentially eligible for.

7. The Department stopped that Appellant's HHS payments as of (Exhibit 2, page 3)

8. There was no evidence that any written notice of the HHS termination was issued to the Appellant.

9. The Appellant's mother was his HHS provider, and continued to provide care and services to the Appellant after the HHS payments stopped. (Mother Testimony)

10. The Appellant's Medicaid eligibility returned to full coverage Medicaid in (Exhibit 1, page 8)

11. The Appellant reapplied and was approved for HHS with payments starting as of . pproval made more than after the start date. (Exhibit 1, page 2)

12. On , a request for an administrative hearing was received regarding the lost earnings due to the Medicaid eligibility error. (Exhibit 1, pages 4-7)

13. , the correction of the Appellant's Medicaid eligibility status to full coverage Medicaid was made retroactive to . (Exhibit 1, page 9 and Exhibit 2, page 1)

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.

The Department asserted that the [redacted] hearing request was filed more than 90 days after the [redacted] termination of the Appellant's HHS case. 42 CFR § 431.221(d) requires the agency to allow a reasonable time, not to exceed **90 days from the date that the notice of action is mailed** to request a hearing. (Exhibit 1, page 22, emphasis added by ALJ) Clearly more than 90 days passed between the [redacted] termination and [redacted] filing of the hearing request. However, there was no evidence that a notice of the termination action was ever issued to the Appellant. (Appeals Review Officer Testimony, Mother Testimony, Exhibit 1, page 10) Without issuing a notice of the HHS termination, there was no mailing date to trigger the 90 day time limit for filing a hearing request. Accordingly, the Appellant's [redacted] hearing request is a timely appeal April [redacted] termination of his HHS payments.

The Adult Services Manual (ASM) addresses eligibility for Home Help Services:

> **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.
>
> **Medicaid Personal Care Option**
>
> Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.
>
> Discuss this option with the client and the ES.
>
> Conditions of eligibility:
>
> - The client meets all MA eligibility factors except income.
> - An ILS services case is active on CIMS (program 9).
> - The client is eligible for personal care services.
> - The cost of personal care services is **more** than the MA excess income amount.
> - The client agrees to pay the MA excess income amount to the home help provider.

Adult Services Manual (ASM) 363, 9-1-2008 pages 7-8 of 24.
(See also Adult Services Manual (ASM) 362, December 1, 2007, pages 1-2 of 5)

The Appellant's need for HHS is not at issue in this case. Rather, his HHS case was terminated due to a change in his Medicaid eligibility status that went into effect . Department policy requires a HHS participant to have Medicaid coverage with a qualifying scope of coverage in order to be eligible for the HHS program. Individuals who have met their monthly Medicaid deductible, or spend down, are eligible for HHS. An individual with a spend down can also become eligible for HHS if the monthly care cost exceeds the spend down and the individual agrees to pay the HHS provider the spend down amount. *Adult Services Manual (ASM) 363, 9-1-2008 pages 7-8 of 24.*

In the present case, the Appellant's Medicaid eligibility status change to having a monthly spend down effective which had to be met for the Appellant to be eligible for Medicaid for the remainder of each month. The Appellant's Medicaid spend down was in and changed to effective (Exhibit 1, page 8) The Appellant was authorized for HHS with a total monthly care cost of only (Exhibit 2, page 2) Accordingly, the Appellant was no longer eligible for HHS based on that information available at that time because the amount of his monthly spend down exceeded the potential HHS payment the Appellant would receive

from the Department each month, and he had not otherwise met his monthly spend down.

However, the change of the Appellant's Medicaid eligibility status to having a monthly spend down was an error. The Appellant's Medicaid eligibility status was eventually corrected to full coverage Medicaid with no spend down retroactive to . (Exhibit 1, page 9, Exhibit 2, page 1) Based on the information available now, the Appellant was eligible for HHS payments from the The Appellant's mother provided credible testimony that she continued to provide the care and services that had been authorized under the HHS grant after the payments stopped. (Mother Testimony) There was no evidence that written advance notice of the termination was issued as required under 42 CFR § through and Adult Services Manual (ASM) 362 . Accordingly, the Appellant's HHS case shall be reinstated retroactive to . A new HHS authorization for the Appellant began (Exhibit 2, page 2) Accordingly, HHS payments shall be issued based on a total monthly care cost of from through

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly terminated the Appellant's HHS payments.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Appellant's HHS case shall be reinstated retroactive to and HHS payments shall be issued based on a total monthly care cost of from through .

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

cc:

Date Mailed: 4-30-12

***** 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.