

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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**IN THE MATTER OF:**

██████████,

Appellant.

Docket No. 2014-23377 HHS  
Case No. ██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. The Appellant and the Appellant's Provider (██████████) appeared and offered testimony. ██████████, Appeals Review Officer, represented the Department of Community Health. ██████████, Adult Services Manager (ASM) appeared as witnesses for the Department.

**ISSUE**

Did the Department provide the Appellant with the proper written notices of case action regarding the Appellant's Home Help Services (HHS) case in ██████ and ██████?

Did the Department properly determine the Appellant's eligibility for HHS during ██████ and ██████?

**FINDINGS OF FACT**

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

1. From ██████████ through ██████████, the Appellant was approved for MA with a spenddown. The spenddown amount varied from month to month. (Exhibit A, p. 15)
2. On ██████████, the Department opened a HHS case for the Appellant. (Exhibit A, p. 10; Testimony)
3. On ██████████, the Department sent the Appellant a Services and Approval Notice (1210). (Exhibit A, p. 9)

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4. On [REDACTED], the Department paid the Appellant for HHS that were performed between [REDACTED] and [REDACTED]. (Exhibit A, p. 21)
5. On approximately [REDACTED], the Department stopped issuing HHS payments to the Appellant. (Exhibit A, p. 21)
6. At no point in time between [REDACTED] and [REDACTED] did the Department issue the Appellant written notification of any suspension or closure of her HHS case. (Exhibit A, p. 8)
7. On [REDACTED] the Department sent the Appellant a Negative Action Notice. The notice indicated the appellant's HHS case was being terminated for submitting bills to the MA worker for personal care services provided in the home. (Exhibit A, pp. 6-9).
8. The Appellant met her MA deductible and had a scope of 2F during the periods of [REDACTED] through [REDACTED]. (Testimony)
9. On [REDACTED], the Michigan Administrative Hearings System received from the Appellant a request for hearing. (Exhibit A, pp. 4, 5)

**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 Adult Services Manual (ASM) 105 addresses HHS requirements:

**Requirements**

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment (DHS-324) indicating a

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functional limitation of level 3 or greater for activities of daily living (ADL).

- Appropriate Level of Care (LOC) status.

**Medicaid/Medical Aid (MA)**

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).

Clients with a scope of coverage 20, 2C or 2B are not eligible for Medicaid until they have met their MA deductible obligation.

**Note:** A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

*Adult Services Manual (ASM) 105, 12-2-2013 p. 1*

ASM 170 (5-1-2013) addresses the issue of case closures and negative actions:

**Termination of HHS Payments**

Home help services payments may be terminated and closing procedures initiated, in any of the following circumstances:

- The client fails to meet any of the eligibility requirements.
  - Medicaid eligible.
  - Medical professional does not certify a need for services on the DHS-54A, Medical Needs form.
  - Assessment determines client no longer requires home help services.
- The client no longer wishes to receive home help services.

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- The client is receiving services from another program and this would result in a duplication of services.

### **Notification of the Negative Action**

When home help services are terminated, *suspended* or reduced for **any** reason, a DHS-1212, Advance Negative Action Notice, must be generated in **ASCAP** and sent to the client advising of the negative action and explaining the reason for the action; see ASM 150, Notification of Eligibility to determine need for 10 business day notice of action.

ASM 170, 5-1-2013, pp. 1, 2.

ASM 150 (5-1-2013) addresses the issue of notification of eligibility determinations:

### **Written Notification of Disposition**

All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.
- DHS-1212, Advance Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

### **Advance Negative Action Notice (DHS-1212)**

The DHS-1212, Advance Negative Action Notice, is used and generated on ASCAP when there is a reduction, suspension or termination of services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

### **Negative Actions Requiring Ten Day Notice**

The effective date of the negative action is ten business days **after** the date the notice is mailed to the client. The effective date must be entered on the negative action notice.

***Negative Actions Not Requiring Ten Day Notice***

The following situations **do not** require the ten business day notice on negative actions:

- The department has factual confirmation of the death of the client (negative action notice must be mailed to the guardian or individual acting on the client's behalf) or death of the service provider.

**Note:** Cases should remain open until all appropriate payments have been issued.

- The department receives a verbal or written statement from the client, stating they no longer want or require services, or that they want services reduced.

**Note:** This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The department receives a verbal or written statement from the client that contains information requiring a negative action. The statement must acknowledge the client is aware the negative action is required and they understand the action will occur.

**Example:** A home help services client informs the specialist that they are engaged and will be married on a specific date. They also acknowledge that their new spouse will be responsible for meeting their personal care needs and they will no longer qualify for home help services.

**Note:** This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

ASM 150, 5-1-2013, pp. 1-4.

ASM 170 (5-1-2013) addresses the issue of notification of reopening a services case:

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**Reopening a Services Case**

If a case has closed and reopens within 90 days, a new DHS-390, Services Application and DHS-54A, Medical Needs form are **not** required.

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The first issue I will address is the time period in question. The documentation provided by the Department shows the HHS case was opened on ██████████. And while the Appellant wishes to go back further in time, she has failed to present any physical evidence of their being an active open case in this office location prior to ██████████.

The Department argues, they should only go back as far as ██████████ as it is the most recent action (action date of the most recent negative action notice). I disagree. The documentation and testimony regarding the notices provided to the Appellant during ██████ and ██████ was seriously lacking. Although a 1210 was issued on ██████████, there was no testimony as to what specifically this document indicated and no evidence of whether or not it addressed a spenddown. For these reasons, I don't find the Appellant to have been properly put on notice at any point in time regarding the changes to her HHS case in ██████. Consequently, I find a good cause reason to toll the time limit requirements for requesting a hearing on any issues arising in ██████ and early ██████.

Furthermore, Department records shows HHS Payments were issued for November and ██████████ of ██████ with payments stopping on ██████████. Therefore, I find the time period in question is from ██████████ through ██████████.

The Department argued, the Appellant was not eligible for HHS due to the Appellant either using the cost of the HHS to meet her spenddown and/or for not meeting the spenddown.

Reviewing, the applicable policy (ASM 170), there is a limited number of situations where the Department can close/suspend a HHS case. The Appellant using the cost of HHS to meet their spenddown is not one those situations.

The only argument the Department has for closing or suspending HHS payments is the Appellant not meeting her spenddown. However, the facts in this case do not align themselves with that argument. At all times in question, the Appellant had a coding of 2F meaning the Appellant met the MA eligibility requirement to be eligible for HHS.

Therefore, based on the evidence presented, I find, the Department improperly suspended/closed the Appellant's HHS case and did not provide the Appellant with the proper notices.

**DECISION AND ORDER**

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

**IT IS THEREFORE ORDERED THAT:**

1. The Department's decision is **REVERSED**.
2. The Department is ordered to reopen the Appellant's HHS case with an effective date of [REDACTED] and issue retroactive benefits if otherwise eligible and qualified.

  s  \_\_\_\_\_

Corey A. Arendt  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

[REDACTED]  
cc: [REDACTED]

Date Signed: February 28, 2014

Date Mailed: February 28, 2014

**\*\*\* 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.