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

IN THE MATTER OF:

Appellant
_____________________/

Docket No. 2009-23205 EDW
Case No

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, following the Appellant's request for a hearing.

After due notice, a hearing was held on appeared on behalf of their daughter,).

Director of Quality, , Nurse Case Manager, , Clinical Manager, and , Care Manager, appeared on behalf of HHS Health Options, an agency contracted with the Department of Community Health to provide MI Choice Wavier Services (hereafter, 'Department').

ISSUE

Did the Department properly deny the Appellant's request for 14 hours per week of personal care services?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary, and is enrolled in the MI Choice Waiver program. After her , initial program assessment, the Appellant was provided 22 hours per week in-home respite services to accommodate

her mother's out-of-home work schedule. At that time, the Appellant's father was not working outside of the home and provided the Appellant's care.

2. On [redacted], the Appellant requested an additional 14 hours per week of personal care assistance, as the Appellant requires a 2-person transfer and around the clock care.

3. On [redacted], the Department performed a re-assessment which reflected improvement in the Appellant's lower extremity mobility. Thus, on [redacted], the request for an additional 14 hours of personal care assistance was denied.

4. On [redacted], the parties met and discussed the Appellant's diagnosis of progressive multiple sclerosis, with increased incidence of hand tremors. It was decided that, because of the tremors, the Appellant needed occasional assistance with meals.

5. With the new clinical information in-hand, the Department offered a change to the Appellant's care plan, which offered an additional 6 hours of personal care per week. With the existing 5 hours of personal care already awarded, the additional six would provide the Appellant with 11 hours of personal care each week, in addition to the 22 hours per week of respite care. The Appellant's family declined this offer.

6. The Appellant's mother is no longer working outside of the home. The Appellant's father also is not working outside of the home. *(Hearing testimony)*

7. On [redacted], the Appellant filed her request for hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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 Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

This Appellant is claiming services through the Department's Home and Community Based Services for Elderly and Disabled (HCBS/ED). The waiver is called MI Choice in Michigan. The program is funded through the federal Health Care Financing Administration to the Michigan Department of Community Health (Department). Regional agencies, in this case Region II Area Agency on Aging, function as the Department's administrative waiver agency.

Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter. *42 CFR 430.25(b)*

A waiver under section 1915(c) of the [Social Security] Act allows a State to include as "medical assistance" under its plan, home and community based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF [Skilled Nursing Facility], ICF [Intermediate Care Facility], or ICF/MR [Intermediate Care Facility/Mentally Retarded], and is reimbursable under the State Plan. *42 CFR 430.25(c)(2)*

Home and community-based services under section 1915(c) exist for a period of three years initially, and may be renewed thereafter for periods of five years. *42 CFR 430.25(h)(2)(i)*

CMS [Centers for Medicare and Medicaid Services] may grant a State an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. CMS will consider this option when it requests additional information on a new waiver request submitted by a State to extend its existing waiver or when CMS disapproves a State's request for extension. *42 CFR 441.304(c)*

1915 (c) (42 USC 1396n (c)) allows home and community based services to be classified as "medical assistance" under the State Plan when furnished to recipients who would otherwise need inpatient care that is furnished in a hospital SNF, ICF or ICF/MR and is reimbursable under the State Plan. 42 CFR 430.25(b)

Home and community based services means services not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter. 42 CFR 440.180(a)

Included services. Home or community-based services may include the following services, as they are defined by the agency and approved by HCFA:

- Case management services.
- Homemaker services.
- Home health aide services.
- Personal care services.
- Adult day health services
- Habilitation services.

- Respite care services.
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

Other services requested by the agency and approved by HCFA as cost effective and necessary to avoid institutionalization. 42 CFR 440.180(b)

Determination of personal care services

The MI Choice waiver defines Personal Care as follows:

"Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service may also include assistance with the preparation of meals but does not include the cost of the meals. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. . . ."

(MI Choice Waiver, Updated September 2002; Appendix B, pages B1 and B2)

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *See 42 CFR 440.230.* The MI Choice Waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary.

The Operating Standards applicable to the MI Choice Waiver Program require Waiver Agents to develop written policies and procedures compatible with the "General Operating Standards for Waiver Agents and Their Contracted Service Providers."

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied his burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

The Appellant's mother testified the primary reason for the requested increase is her desire

for financial assistance, as neither she nor her husband are currently working outside of the home. The Appellant's father testified that, as a result of having to constantly care for the Appellant, he becomes frustrated with the Appellant's mother which leads to bickering between them. He also described pain associated with a dual hip replacement.

The Appellant's parents otherwise presented no further evidence in support of their contention that 14 hours of personal care are medically necessary. Accordingly, they have failed to carry their burden under current law and/or policy.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Department has appropriately denied the Appellant's request for 14 hours per week of personal care assistance.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 9/15/2009

***** 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.