STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARINGS 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:

[redacted],

Appellant

_____/

Docket No. 2011-51772 EDW
Case No. 68908525

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 on Wednesday, [redacted]. Attorney [redacted] appeared and represented the Appellant. Ms. [redacted], Appellant, appeared and testified in her own behalf. [redacted], Appellant's friend/caregiver was also present for the hearing.

[redacted], Director of Quality and Training, represented the Department's MI Choice Waiver Agency, HHS, Health Options. [redacted], R.N. Clinical Manager for HHS appeared as a witness on behalf of the Waiver Agency, HHS, Health Options.

ISSUE

Did the MI Choice Waiver Agency properly reduce the Appellant's Community Living Supports (CLS) from 36 hours per week to 28 hours per week?

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 Department contracts with HHS, Health Options (HHS or waiver Agency) to provide MI Choice Waiver services to eligible beneficiaries.

2. HHS must implement the MI Choice Waiver program in accordance to Michigan's waiver agreement, Department policy and its contract with the Department.

3. Appellant is a [redacted] year old (DOB [redacted]) Medicaid beneficiary.

4. Appellant has been enrolled in the MI Choice Waiver program for about

five years. Appellant is receiving Medicaid covered services which include CLS, a nutritional supplement, home delivered meals, and a private duty nurse weekly. (Testimony).

5. Appellant's primary diagnoses are epilepsy/seizure disorder and traumatic brain injury. (Exhibit 6, page 9, 15).

6. On [redacted], the MI Choice waiver team performed a reassessment of the Appellant at [redacted] Center ([redacted]) an outpatient clinic that is part of [redacted] Hospital. (Exhibit 6).

7. On [redacted], a care planning conference was held at [redacted] with the Waiver Agency, the Clinic, the Appellant, the Appellant's attorney, and the Appellant's primary care physician present. The Waiver Agency advised that it could not provide services for the Appellant while in the facility. The Clinic indicated they could not provide treatments without a caregiver in attendance. (Testimony).

8. Based on the lengthy outpatient treatments Appellant was receiving at the [redacted] Center, the MI Choice Waiver Agency determined there was medical need for only 28 CLS hours per week and, therefore, reduced the Appellant's CLS hours per week to 28 per week. Based on her functional status it was determined that two hours of care in the morning and two hours each evening would meet Appellant's basic needs. (Exhibit 1).

9. On [redacted], the MI Choice Waiver Agency provided Appellant advance notice of a reduction in CLS hours from 36 hours per week to 28 hours per week and suspension of self determination due to not providing a caregiver who could be paid. (Exhibit 2, p. 2).

10. On [redacted], MAHS received Appellant's request for a hearing to contest the reduction of CLS hours and the suspension of self determination. (Exhibit 8).

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 Centers for Medicare and Medicaid (formerly HCFA) to the Michigan Department of Community Health

(Department). Regional agencies, in this case an Area Agency on Aging (AAA), function as the Department's administrative 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 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).
>
> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> - 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 CMS as cost effective and necessary to avoid institutionalization. 42 CFR 440.180(b).

The Michigan Department of Community Health, Medical Services Administration issued bulletin number MSA 11-27 on July 1, 2011, effective August 1, 2011, for the purpose of adding a MI Choice Policy Chapter to the Medicaid Provider Manual. This new policy chapter provides in part:

> SECTION 1 – GENERAL INFORMATION
>
> MI Choice is a waiver program operated by the Michigan Department of Community Health (MDCH) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria that supports required long-term care (as opposed to rehabilitative or limited term stay) provided in a nursing facility. The waiver is approved by the Centers for Medicare and Medicaid Service (CMS) under section 1915(c) of the Social Security Act. MDCH carries out its waiver obligations through a network of enrolled providers that operate as organized health care delivery systems (OHCDS). These entities are commonly referred to as waiver agencies. MDCH and its waiver agencies must abide by the terms and conditions set forth in the waiver.
>
> MI Choice services are available to qualified participants throughout the state and all provisions of the program are available to each qualified participant unless otherwise noted in this policy and approved by CMS. (p. 1).
>
> * * *
>
> 3.1.B. INSTITUTIONAL STAYS
>
> There are occasions when a MI Choice participant might require a short-term admission to an institutional setting for treatment. The impact of such an institutional stay is dependent on the type of admission and the length of the stay.
>
> A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of waiver services during the hospital stay to avoid unnecessary or redundant service delivery from the hospital or MI Choice, however the supports coordinator should not remove the individual from MI Choice. A participant who is hospitalized for more than 30 days must have his/her enrollment suspended.

A participant admitted to a nursing facility for rehabilitation services or for any reason must be removed from MI Choice on the date prior to the nursing facility admission. The person may be re-enrolled into MI Choice upon discharge from the nursing facility, subject to the enrollment status of the agency. (p. 6).

* * *

4.1.I. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) services facilitate an individual's independence and promote reasonable participation in the community. Services can be provided in the participant's residence or in a community setting to meet support and service needs.

CLS may include assisting, reminding, cueing, observing, guiding, or training with meal preparation, laundry, household care and maintenance, shopping for food and other necessities, and activities of daily living such as bathing, eating, dressing, or personal hygiene. It may provide assistance with such activities as money management, non-medical care (not requiring nurse or physician intervention), social participation, relationship maintenance and building community connections to reduce personal isolation, non-medical transportation from the participant's residence to community activities, participation in regular community activities incidental to meeting the individual's community living preferences, attendance at medical appointments, and acquiring or procuring goods and services necessary for home and community living.

CLS staff may provide other assistance necessary to preserve the health and safety of the individual so they may reside and be supported in the most integrated independent community setting.

CLS services cannot be authorized in circumstances where there would be a duplication of services available elsewhere or under the State Plan. CLS services may not be authorized in lieu of, as a duplication of, or as a supplement to similar authorized waiver services. The distinction must be apparent by unique hours and units in the individual's plan of service. Tasks that address personal care needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care service in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.

> When transportation incidental to the provision of CLS is included, it must not also be authorized as a separate waiver service. Transportation to medical appointments is covered by Medicaid through the State Plan.
>
> Community Living Supports do not include the cost associated with room and board. (pp. 13-14).

The MI Choice waiver is a Medicaid-funded program and its Medicaid funding is a payor of last resort. In addition, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *42 CFR 440.230.* In order to assess what MI Choice waiver program services are medically necessary, and therefore Medicaid-covered, the MI Choice waiver program performs periodic assessments.

The Appellant was receiving 36 CLS hours per week, 4 hours under self determination through the MI Choice waiver. On [redacted], the Waiver Agency sent an advance action notice to reduce the hours to 28 per week. The Appellant appealed the reduction, and thus, bears the burden of proving, by a preponderance of evidence that the additional 8 hours per week are medically necessary.

The Waiver Agent's witness, [redacted], R.N., the Clinical Manager for the MI Choice Waiver program, testified that an assessment of medical necessity for CLS hours was made based on an [redacted] reassessment of the Appellant, her independence in her activities of daily living, and where she needs assistance. They were also required to take into consideration other resources available to the Appellant in the community as the MI Choice program is a payor of last resort.

[redacted] stated that a determination was made that Appellant's CLS hours would be reduced from 36 hours per week down to 28 hours per week due to the fact that Appellant was in a hospital setting receiving daily infusion treatments Monday through Friday 4 to 6 hours per day at [redacted] Center in an outpatient treatment facility that is part of [redacted] Hospital.

[redacted] testified that it was the hospital staff's responsibility to provide the necessary care and insure the safety of the Appellant while she was there for her treatments. Accordingly, the MI Choice program could not provide CLS hours to pay a caregiver to attend the Appellant while she was at [redacted] for her treatments. [redacted] believed that Medicaid was paying for the treatments and also providing CLS hours would be considered a duplication of services.

[redacted] sent out the advance action notice on [redacted], which would have reduced the CLS hours from 36 to 28 hours. Also 4 hours of self determination was suspended due to the fact that there was no qualified caregiver/employee approved who could provide CLS services. The 28 hours were to be provided by the traditional provider contracted to provide such services, i.e., [redacted].

[redacted] testified that Exhibit 3, paragraph 4 of Attachment K dealing with hospital admissions, was submitted as an exhibit because it provides that waiver agents do not provide MI Choice services, except supports communication/case management, to participants while they are hospitalized. [redacted] stated that this covers any length of stay in the hospital.

Exhibit 4, Attachment H was also submitted which defines the services provided under Community Living Supports. [redacted] acknowledged that CLS does include attendance at a regularly scheduled doctor's appointment in the doctor's office, but it would be a duplication of services to provide CLS hours for someone to provide care during Appellant's hospitalization at [redacted] Center for her infusion treatments. [redacted] stated it would be up to the hospital staff to provide such care while Appellant was in the hospital.

The Appellant testified she has been receiving services through HHS for about 5 years. Appellant stated she has had a caregiver present while receiving her treatments at [redacted]. The caregivers were providing her similar support that they would have if she were at home such as assisting her with going to the bathroom, assisting with her lunch, keeping her to her routine, keeping daily notes, and even assisting with her physical therapy exercises while she was at [redacted]. Appellant stated she had a seizure during the reassessment conducted on [redacted]. Appellant also stated she has three people who have qualified to be caregivers for CLS purposes, [redacted], [redacted] and [redacted].

Appellant presented a letter from her primary care physician Dr. [redacted], D.O., indicating she requires daily infusions of IV fluids, IV antinausea and antiseizure medications, and at times pain medications. Dr. [redacted] further indicated this requires a 4 to 8 hour stay in [redacted] infusion center where, because of her seizure history, she needs a full time attendant which cannot be supplied by the infusion center. (Exhibit 7).

This ALJ finds the MI Choice agency did authorize 28 hours per week as an appropriate number of CLS hours to meet the medically necessary needs of the Appellant. The Appellant failed to establish by a preponderance of the evidence that the additional 8 CLS hours per week were medically necessary. Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services, thus additional CLS services cannot be authorized for the Appellant based upon the evidence of record. *42 CFR 440.230.*

The Waiver Agency determined that the lengthy infusion treatments were being given in a hospital setting and that according to policy, waiver services could not be provided (must be suspended) during short term hospitalizations. The Waiver Agent argued that it was the hospital staff's responsibility to provide proper care and treatment while the Appellant was in the hospital for such treatments.

The policy governing CLS services does allow for caregivers to provide non-medical care (not requiring nurse or physician intervention), however, it is clear that the infusion treatment require the intervention of a nurse, physician, or other trained medical staff,

something a CLS provider is unable to do. Furthermore, CLS services do include attendance at medical appointments, which the Waiver Agent has determined covers only routine office visits at a physician's office, and not lengthy treatments in a hospital setting of anywhere from 4 to 8 hours per day, 5 days per week. The Waiver Agency considers this a short term hospitalization during which waiver services are not available.

Appellant has failed to meet her burden of showing that the additional 8 CLS hours being requested are both medically necessary and authorized by the MI Choice Waiver policy cited above. The question of self determination, previously authorized at 4 hours per month, is really not at issue as the Waiver Agent is in agreement with allowing self determination for 4 hours as long as there are qualified individuals who can be approved for employment for these services.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, this Administrative Law Judge finds the MI Choice Waiver Agency properly reduced the Appellant's personal care hours to 28 per week.

IT IS THEREFORE ORDERED that:

The MI Choice Waiver Agency's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/31/2011

***** 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.