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) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 2013-21414 EDW
Case No. [redacted]

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 on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Appellant's son and caregiver, appeared as a witness for Appellant.

[redacted], Director of Community and Clinical Services, appeared and testified on behalf of the Department's Waiver Agency, [redacted]. ([redacted] or Waiver Agency). [redacted], Program Manager, appeared as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency properly reduce Appellant's Community Living Supports (CLS) from 40 hours per week to 37 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 [redacted] to provide MI Choice Waiver services to eligible beneficiaries. (Testimony)

2. [redacted] must implement the MI Choice Waiver program in accordance with Michigan's waiver agreement, Department policy and its contract with the Department. (Exhibit A)

3. The Appellant is a [redacted] year-old female, born [redacted]. Appellant's diagnoses include congestive heart failure, hypertension, history of stroke, fibromyalgia, chronic pain syndrome, degenerative disc disease,

migraines, and asthma. Appellant has also had 9 tumors removed from her body. (Testimony)

4. The Appellant lives alone in a single family home. Appellant's son and caregiver often stays with Appellant when he is not attending school. (Exhibit A, Testimony)

5. On or about [redacted], Appellant was enrolled in Hospice and began receiving, among other services, a bath aide for 3 hours per week. (Exhibit A, pp 6-9; Testimony)

6. On [redacted], the Waiver Agency notified Appellant via Adequate Action Notice that her CLS hours would be reduced from 40 to 37 hours per week to avoid a duplication of the bathing services Appellant was receiving through Hospice. (Exhibit A, p 5; Testimony).

7. On [redacted], the Michigan Administrative Hearing System received Appellant's request for hearing. (Exhibit 1). In her request for hearing, Appellant stated:

> 1) Request right to choose who hours are dispersed to. 2) Need to increase total hours. 3) Look into poor attitude and threats to cut more benefits when questioned coordinator. 4) Taking money from check before hearing is finished. (Exhibit 1)

8. On [redacted], as a result of Hospice terminating services, the Waiver Agency increased Appellant's CLS hours back to 40 hours per week. (Exhibit A, p 1; Testimony)

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 the [redacted], 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 MI Choice Policy Chapter to the *Medicaid Provider Manual*, *MI Choice Waiver*, provides in part:

4.1 COVERED WAIVER SERVICES

In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections. [p. 9].

4.1.I. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) services facilitate a participant'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, nonmedical 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 participant'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 participant so they may reside and be supported in the most integrated and 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 cannot 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 plan of services. 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.

4.3 HOSPICE

MI Choice participants may receive State Plan-covered hospice services while participating in MI Choice. Participants must meet all hospice eligibility requirements outlined in the Hospice Chapter. If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services.

State Plan Hospice services must be used to the fullest extent before similar MI Choice services are authorized. Inappropriate services (e.g., duplicative, non-covered) are subject to MDCH recovery of the amounts paid for those services from the waiver agency.

A joint plan of service for Hospice and MI Choice must be developed and maintained by both the waiver agency and the hospice provider. It is important that the waiver agency understand the hospice philosophy so the two entities work for a common goal and avoid redundant services. Ongoing communication and coordination must occur between the MI Choice supports coordinator and the hospice provider during the time they are serving the participant. Written documentation of this communication and coordination must be kept in the participant's record at each agency.

Medicaid Provider Manual
MI Choice Waiver Section
April 1, 2013, pp 12-17

The MI Choice Waiver Program 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 Waiver Agency performs periodic assessments.

The Appellant bears the burden of proving, by a preponderance of evidence, that her CLS hours were improperly reduced.

The Waiver Agency's Director testified that Appellant's CLS hours were reduced by 3 hours per week when it was discovered that Appellant was receiving a bathing aide for 3 hours per week through Hospice. The Waiver Agency's Director indicated that the Waiver Agency is required by policy to coordinate services when another agency is providing services to ensure against inappropriate or duplicative services. (Exhibit A, p 4). The Waiver Agency's Director also testified that Appellant's CLS hours have since been reinstated to 40 hours per week following the termination of her Hospice in February 2013.

Appellant testified that she appealed because, while she was still receiving 40 hours of services per week, the amount reimbursed to her son and caregiver was reduced when the Waiver Agency reduced her hours. Appellant testified that she should be able to allocate her care hours as she wishes. Appellant indicated that her son also needs the money he receives from the Waiver Agency as her paid caregiver and that the money is necessary to maintain the household. Appellant indicated that her son could find another full-time job that paid more. Appellant indicated that her CLS hours have been reinstated to 40 hours per week, but that she lost her [redacted] when the CLS hours went back up to 40 hours per week.

The Waiver Agency's Program Manager testified that Appellant's Meals on Wheels were eliminated in [redacted], but that the elimination had nothing to do with Appellant's CLS hours being reinstated. Instead, according to the Waiver Agency's Program Manager, Appellant's Meals on Wheels were eliminated because the logs that her son and caregiver submitted demonstrated that he was home during Appellant's meal times. Per policy, the Waiver Agency's Program Manager indicated that Appellant cannot receive [redacted] if someone is home to provide her meals. The Waiver Agency's Program Manager also indicated that Appellant was provided a separate Adequate Action Notice when her [redacted] were eliminated and that Appellant did not appeal that decision.

Appellant admitted that she did not appeal the [redacted] decision because she did not think it was necessary, given that she had a hearing upcoming on the CLS issue. Appellant also admitted that her son was usually home when she received her [redacted] because he would reheat the meals and set out her silverware.

The Waiver Agency's Director testified that the Waiver Agency offered to Appellant the services of an outside agency to provide her care so that her son could find a better job or go to school. Appellant refused this offer, stating that she has tried outside agencies in the past and that they are not good.

This ALJ finds that the Waiver Agency properly reduced Appellant's CLS from 40 to 37 hours per week when Appellant was receiving the duplicative service of a bath aide from Hospice. Policy requires that the Waiver Agency must coordinate services with Hospice to avoid a duplication in services. It is also determined that even though Appellant did not properly appeal the elimination of [redacted], that reduction was also appropriate given the fact that Appellant's caregiver was home during Appellant's meal time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MI Choice Waiver agency properly reduced Appellant's CLS hours from 40 to 37 hours per week.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: 5/9/2013

Date Mailed: 5/9/2013

***** 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.