

**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:

██████████,

Appellant

Docket No. 2013-37460 EDW
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 ██████████. Appellant appeared and testified on his own behalf. ██████████, Appellant's brother, was also present during the hearing. ██████████, Clinical Manger, represented the Department of Community Health's Waiver Agency, the ██████████ ("Waiver Agency" or "AAA"). ██████████, supports coordinator, also testified as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency proper reduce Appellant's services through the MI Choice waiver program?

FINDINGS OF FACT

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

1. Appellant is a ██████ year-old male who has been diagnosed with hypertension, arthritis, anxiety, depression, renal failure, diabetes mellitus, psoriasis, sleep apnea, and obesity. Appellant also has a history of back surgeries and had a hairline fracture on his right foot in ██████. (Respondent's Exhibit C, pages 1, 8-9, 12; Respondent's Exhibit F, pages 11-12).
2. AAA is a contract agent of the Michigan Department of Community Health (MDCH) and is responsible for waiver eligibility determinations and the provision of MI Choice waiver services.
3. Appellant has been enrolled in and receiving MI Choice waiver services through AAA, including 40 hours a week of Community Living Supports

(CLS) through the agency's self-determination program. (Testimony of Appellant; Testimony of ██████████).

4. Appellant's CLS had been increased to 40 hours a week at the end of ██████████ after Appellant suffered a hairline fracture on his right foot and required more assistance. (Respondent's Exhibit F, page 11; Testimony of ██████████).
5. On ██████████, Shtulman conducted a home visit and reassessment with Appellant. (Respondent's Exhibit C, pages 1-18).
6. During that assessment, Appellant reported, with respect to his right foot, that he underwent an X-ray the previous week and the doctor told him the foot was healing. Appellant was not wearing a boot cast at the time, but also reported that he wears it when he goes outside. (Testimony of ██████████; Respondent's Exhibit C, page 9).
7. Appellant transferred and ambulated with a walker independently during the home visit. (Testimony of Appellant; Respondent's Exhibit C, page 9).
8. ██████████ also observed that Appellant bent from the waist and picked up the walker when using it, rather than just sliding it. (Respondent's Exhibit C, page 9).
9. Given Appellant's functional improvement, AAA decided to reduce his CLS services and remove the additional hours authorized after Appellant injured his foot. (Testimony of ██████████; Respondent's Exhibit F, page 11).
10. On ██████████, AAA sent Appellant a written Advance Action Notice that his CLS would be reduced 12 days from the date of the notice. (Respondent's Exhibit A, page 1).
11. On ██████████, the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed by Appellant. (Petitioner's Exhibit 1, pages 1-6).
12. The reduction was not implemented and Appellant's were maintained at their current level while the appeal was pending. (Testimony of Appellant; Testimony of ██████████).

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.

Appellant is claiming services through the Department's Home and Community Based Services for Elderly and Disabled. The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid Services to the Michigan Department of Community Health (Department). Regional agencies, in this case 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. See 42 CFR 430.25(c)(2).

Types of services that may be offered include:

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).]

In this case, Appellant has been receiving Community Living Supports (CLS). With respect to CLS, the applicable version of the Medicaid Provider Manual (MPM) states:

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. [MPM, January 1, 2013 version, MI Choice Chapter, pages 12-13.]

Here, it is undisputed that the Appellant has a need for some CLS and he has continuously been receiving such services. However, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services and the MI Choice waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. See 42 CFR 440.230.

With respect to Appellant's needs in this case, the Waiver Agency found that it could reduce Appellant's CLS services and remove the additional hours authorized after Appellant injured his foot given Appellant's functional improvement. Specifically, the Waiver Agency relied upon Appellant's own reports that his foot was healing and ██████████ observations that Appellant could transfer and ambulate with a walker independently during the home visit. ██████████ also observed that Appellant bent from the waist and picked up the walker when using it, rather than just sliding it.

In response, Appellant does not dispute that he ambulated with his walker independently. Instead, Appellant testified and argued that he was only able to stand up and walk independently during the home visit because he was so excited to see ██████████. Appellant also testified that, after the home visit, he learned that his foot has not fully healed and it was not even fully healed as of the day of the hearing. Appellant further testified about his worsening health in general since the home visit and the specific surgeries or treatment he has coming up soon.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in reducing his services. Additionally, this Administrative Law Judge is limited to reviewing the Waiver Agency's decision in light of the information available at the time it made its decision. In this case, given the information available at

the time of the decision, Appellant has failed to meet his burden of proof. [REDACTED] credibly testified regarding what Appellant reported or she observed during the home visit and, given Appellant does not dispute that testimony, the Waiver Agency properly found that it could reduce Appellant's CLS services and remove the additional hours authorized after Appellant injured his foot.

To the extent Appellant has updated information, his health has worsened, or he has surgeries scheduled for the future, he would have to make a new request for additional CLS from the Waiver Agency.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly reduced Appellant's services.

IT IS THEREFORE ORDERED that:

The Waiver Agency's decision to reduce Appellant's waiver services is **AFFIRMED**.

Steven Kibit

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

[REDACTED]
Date Signed: 6/21/2013

Date Mailed: 6/21/2013

cc: [REDACTED]

***** 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.