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]

Appellant

Docket No. 2013-64289 EDW
Case No. [redacted]

/

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], RN, Clinical Manager, appeared and testified on behalf of the Department's Waiver Agency, [redacted] ([redacted] or Waiver Agency). The Waiver Agency's witnesses were [redacted], RN, Supports Coordinator and [redacted], LBSW, Supports Coordinator.

ISSUE

Did the Waiver Agency properly deny Appellant's request for additional care hours through self-determination?

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. (Exhibit A; 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; Testimony)

3. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], who is diagnosed with paraplegia, hypertension, peripheral vascular disease, arthritis, osteoporosis, carpal tunnel syndrome and hyperlipidemia. (Exhibit A, pp 14-15; Testimony)

4. Appellant lives in a home she owns with her brother Richard, his wife [redacted], who is also her paid caregiver through self-determination, and her niece [redacted]. (Exhibit A, p 11; Testimony)

5. Appellant currently receives [redacted] care hours per week through self-determination. At Appellant's reassessment on [redacted], Appellant requested additional care hours through self-determination. (Exhibit A, pp 21-22; Testimony)

6. On [redacted], [redacted] notified Appellant that her request for additional care hours through self-determination was denied. (Exhibit A, p 1; Testimony).

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

> I am a bed confined handicapped individual and the 20 hours allotted weekly for my care is not enough. Attached are actual hours used for my care, given to [redacted] my Care Manager at Area Agency on Aging Region 2. (Exhibit 1)

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 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*, July 1, 2012, 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.
>
> *Medicaid Provider Manual*
> *MI Choice Waiver Section*
> *July 1, 2013, pp 12-13*

The MI Choice Waiver Contract FY 2013, Attachment I, page 49 provides: "MI Choice services are not used to replace existing unpaid supports but rather to bolster and help sustain ongoing family involvement."

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.

Appellant bears the burden of proving, by a preponderance of evidence, that additional care hours through self-determination are medically necessary.

The Waiver Agency Clinical Manager testified that Appellant lives in her own home with three family members who currently provide informal assistance in addition to the paid, formal support provided by Appellant's sister-in-law. The Waiver Agency Clinical Manager indicated that, per policy, MI Choice services are not used to replace existing unpaid supports but rather to bolster and help sustain ongoing informal support.

The Waiver Agency Supports Coordinator testified that when she conducted Appellant's most recent assessment, Appellant's needs changed only minimally. The Waiver Agency Supports Coordinator indicated that Appellant is already receiving close to the maximum number of hours in all areas because of her severe disabilities. However, the Waiver Agency Supports Coordinator indicated that hours for cleaning and meal preparation are prorated because Appellant lives in a shared household. The Waiver Agency Supports Coordinator did indicate that some of the hours taken away for housework and meal preparation were transferred to the areas of bathing and transferring because Appellant does require extensive assistance.

Appellant testified that her sister-in-law caregiver puts in way more time than what she is paid for, especially on days when Appellant has doctor's appointments. Appellant indicated that she has had her caregiver track and turn in the actual hours that she works so that the Waiver Agency can see how much she is doing. Appellant also testified that she recently broke her leg, which has led to the need for even more assistance.

The Waiver Agency Clinical Manager testified that the Waiver Agency will be conducting a new assessment because of Appellant's recent broken leg.

This ALJ finds the Waiver Agency properly denied Appellant's request for additional care hours through self-determination. Appellant lives in her own home with three family members who currently provide informal assistance in addition to the paid, formal support provided by Appellant's sister-in-law. Per policy, MI Choice services are not used to replace existing unpaid supports but rather to bolster and help sustain ongoing informal support.

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 denied Appellant's request for additional care hours through self-determination.

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: October 16, 2013

Date Mailed: October 16, 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.