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. 14-012434 EDW
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. Appellant personally appeared and testified. [redacted] appeared as a witness for Appellant.

[redacted], Manager of [redacted], represented the Department's MI Choice Waiver Agency, [redacted], Michigan (Agency). [redacted], Social Worker Support Coordinator, appeared as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency properly reduce the Appellant's MI Choice Waiver services?

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 Appellant is a [redacted] year-old male Medicaid beneficiary enrolled in the MI Choice Waiver program.

2. Appellant has been diagnosed with multiple impairments, including COPD, HBP, CAD, arthritis, anxiety, depression, and stroke. (Exhibit A.7,8)

3. Appellant had previously been approved for 55 hours per week. Appellant was a nursing home resident for rehab. Upon Appellant's return home and after his MA was reactivated, on [redacted] the Agency completed a reassessment. (Exhibit A.3)

4. At the time of the reassessment Appellant was receiving many additional skilled and unskilled care services, including physical therapy, occupational therapy, speech therapy, a visiting nurse, and a bath aide. Appellant's informal supports were providing 2 hours per day-1 hour in the morning and 1 hour in the evening; Appellant was purchasing 2 hours of care per day. (Exhibit A; Testimony)

5. The Agency's reassessment calculated 25.5 hours of care per week based on the multi-factorial assessment. On [redacted] the Agency issued a Notice of Case indicating a denial of services. Agency testimony indicated that the action was a denial of more hours, or reduction. (Exhibit A.4,5; Testimony)

6. At no time did Appellant inform the Agency that any of his support services were reduced or stopped. (Testimony)

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's hearing request, protesting the reduction of his MI Choice Waiver Services.

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.

Effective November 1, 2004, the Michigan Department of Community Health (MDCH) implemented revised functional/medical eligibility criteria for Medicaid nursing facility, MI Choice, and PACE services. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria.

The 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 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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:

> **4.1.B. HOMEMAKER**
>
> Homemaker services include the performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker when the individual regularly responsible for these activities, i.e., the participant or an informal supports provider, is temporarily absent or unable to manage the home and upkeep for himself or herself. Each provider of Homemaker services must observe and report any change in the participant's condition or of the home environment to the supports coordinator.
>
> **4.1.C. PERSONAL CARE**
>
> Personal Care services encompass a range of assistance to enable program participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Personal Care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law.
>
> Services provided through the waiver differ in scope, nature, supervision arrangement, or provider type (including provider training and qualifications) from Personal Care services in the State Plan. The chief differences between waiver coverage and State Plan services are those services that relate to provider qualifications and training requirements, which are more stringent for personal care provided under the waiver than those provided under the State Plan.
>
> Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. These services may also include assistance with more complex life activities. The service may include the preparation of meals but does not include the cost of the meals themselves. When specified in the plan of service, services may also include such housekeeping chores as bed making, dusting, and vacuuming that are incidental to the service furnished or that are essential to the health and welfare of the participant rather than the participant's family. Personal Care may be furnished outside the participant's home.

(MSA 11-27, pages 10-11)

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

The *Medicaid Provider Manual, MI Choice Waiver*, April 1, 2014, 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].
>
> * * *
>
> **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.B. HOMEMAKER**
>
> Homemaker services include the performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker when the individual regularly responsible for these activities, e.g., the participant or an informal supports provider, is temporarily absent or unable to manage the home and upkeep for himself or herself. Each provider of Homemaker services must observe

and report any change in the participant's condition or of the home environment to the supports coordinator. [p. 9, emphasis added].

4.1.C. PERSONAL CARE

Personal Care services encompass a range of assistance to enable program participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This may take the form of hands-on assistance (actually performing a task for the participant) or cueing to prompt the participant to perform a task. Personal Care services are provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law.

Services provided through the waiver differ in scope, nature, supervision arrangement, or provider type (including provider training and qualifications) from Personal Care services in the State Plan. The chief differences between waiver coverage and State Plan services are those services that relate to provider qualifications and training requirements, which are more stringent for personal care provided under the waiver than those provided
under the State Plan.

Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. These services may also include assistance with more complex life activities. The service may include the preparation of meals but does not include the cost of the meals themselves.

When specified in the plan of service, services may also include such housekeeping chores as bed making, dusting, and vacuuming that are incidental to the service furnished or that are essential to the health and welfare of the participant rather than the participant's family. Personal Care may be furnished outside the participant's home. [p. 10, emphasis added].

* * *

4.1.H. CHORE SERVICES

Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing,

raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them,
and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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. 12-13].

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 issue appealed herein is whether the Waiver Agency properly reduced Appellant's program services at the [redacted] reassessment. As noted in the Findings of Fact, at the time of the reassessment, Appellant had recently been discharged from a nursing home, and was receiving, in his home, an extra-ordinary amount of services which he was not previously receiving when the Agency had previously approved the 55 hours per week. These services included physical, occupational and speech therapy, a bath aide, vising nurse. The Agency explained that the reassessment showed Appellant eligible for about 25 hours per week. The Agency further explained that if and when an individual has a change in supports, upon receipt of that information, the Agency can make a new determination and adjustment in hours as appropriate. However, in this case, unrefuted evidence is that Appellant never reported such change(s) to the Agency.

The purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record. The ALJ at an administrative hearing must base a decision upon the evidence of record focusing at the time of the assessment. The Department cannot be held accountable for evidence it was unaware of at the time of its determination

This ALJ finds that the 25 hours of care assessed by the Agency at the reassessment complies with its policy and procedures based on the information the Agency had at the time of the reassessment. Thus, the Agency is upheld.

However, it should be noted that Appellant may very likely be eligible for more services; certainly the Agency approved more when Appellant was not receiving the many

support services. However, the Agency cannot be held responsible for information it was not privy to as Appellant did not report the same. Nor does this ALJ have jurisdiction to take into account facts which were not in existence as the time of the reassessment.

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 MI Choice Waiver services.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED.**

\s\ Spodarek

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

JS[redacted]

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.