

**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:

Docket No. 2014-16137 EDW

██████████

██████████

██████████

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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████, Appellant's grandson and primary care giver, appeared and testified on Appellant's behalf. ██████████, Director of Quality and Training, appeared and testified on behalf of the Department of Community Health's Waiver Agency, HHS, ██████████ ("Waiver Agency" or "HHS"). ██████████, nurse/case manager, and ██████████ social worker/case manager, also testified as witnesses for the Waiver Agency.

ISSUE

Did the Waiver Agency properly decide to only authorize ██████████ hours per day of Community Living Supports (CLS) for Appellant instead of the ██████████ hours per day she sought?

FINDINGS OF FACT

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

1. HHS 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.
2. Appellant is an ██████████ year-old Medicaid beneficiary who has been diagnosed with congestive heart failure; coronary artery disease; hypertension; arthritis; a hip fracture; renal failure; and a stroke. (Respondent's Exhibit A, page 1; Respondent's Exhibit B, pages 5-6).
3. In ██████████, Appellant was living with her daughter when Appellant fell, injured herself, and was hospitalized. (Testimony of ██████████).
4. Appellant remained in the hospital until being discharged on ██████████. (Testimony of ██████████).

5. After being discharged, Appellant moved into a home containing multiple family members. (Testimony of ██████████).
6. The next day, ██████████ and ██████████ assessed Appellant for MI Choice waiver services. (Respondent's Exhibit B, pages 1-11).
7. Both Appellant and her representative/care provider were present for the assessment. (Testimony of Appellant's representative).
8. During that assessment, ██████████ and ██████████ determined that Appellant qualified for services through Door 4 of the Level of Care Determination (LOCD) utilized in the MI Choice Waiver Program. (Respondent's Exhibit B, page 1).
9. With respect to her needs, Appellant reported being independent with transferring, ambulation, toileting, eating, personal hygiene, dressing, and bathing. (Respondent's Exhibit B, pages 3-4, 8-10; Testimony of ██████████).
10. Appellant also reported needed assistance with managing her medications, managing her finances, transportation, shopping, meal preparation, and housework. (Respondent's Exhibit B, pages 2-4, 8-10; Testimony of ██████████).
11. Following the assessment, the Waiver Agency notified Appellant that it was authorizing █ hours a day of CLS to assist her. (Testimony of Appellant's representative; Testimony of ██████████).
12. On ██████████, the Michigan Administrative Hearing System (MAHS) received a complete Request for Hearing signed by Appellant in this matter. (Petitioner's Exhibit 1, page 1).
13. Following the filing of the request for hearing, the Waiver Agency conducted another reassessment, on ██████████, and determined that Appellant's CLS should remain at █ hours a day. (Respondent's Exhibit C, pages 1-11)

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 HHS, 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, as discussed above, Appellant has been receiving CLS through HHS and, with respect to such services, the Michigan 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, April 1, 2013 version
MI Choice Waiver Chapter, pages 12-13*

However, while CLS is a covered service, Medicaid beneficiaries are still 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.

Here, it is undisputed that the Appellant has a need for some CLS and she has been authorized for such services. Instead, the sole dispute is the amount of CLS hours to be authorized, with the Waiver Agency deciding to only authorize such services █ hours per day and Appellant wanting them to receive them for █ hours per day.

According to the Waiver Agency's witnesses, it allocated Appellant's CLS based on Appellant's reports regarding her needs and her ability to complete much of her personal care, including bathing, dressing, toileting, independently. The Waiver Agency's witnesses also noted that Appellant moved into a new home following her hospitalization and that her new home contained more informal supports.

In response, Appellant's representative testified that Appellant had received █ hours of CLS per day when she was enrolled in the program in █ and that Appellant's health has only gotten worse as she has gotten older. Appellant's representative also testified that Appellant is a proud woman who reported during the assessment that she is capable of performing more than she actually can. Appellant's representative further testified that, while he was present during the assessment and heard Appellant report her needs inaccurately, he never corrected her and that he only answered the questions that were asked of him.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in authorizing her services. In this case, given the above

testimony and evidence regarding Appellant's reports during the home visit, Appellant has failed to meet that burden. Appellant, who does not have a legal guardian, reported reduced limited needs during the assessment and the Waiver Agency is justified in relying on those answers, especially where the care provider is also present during the visit and did not contradict Appellant. Moreover, per policy, the waiver program is the payor of last resort and Appellant also identified multiple informal supports that could assist her in the home. Accordingly, Appellant has failed to meet her burden of proof and the Waiver Agency's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly decided Agency to only authorize two hours per day of CLS for Appellant.

IT IS THEREFORE ORDERED that:

The Waiver Agency's decision is **AFFIRMED**.

Steven Kibit

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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

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.