

**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. 2014-19359 EDW**

████████████████████

████████████████████

Appellant

\_\_\_\_\_ /

**DECISION AND ORDER**

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

After due notice, a hearing was held on ██████████ ██████████ Appellant's daughter ██████████ appeared and testified on the Appellant's behalf.

██████████, Community Services Director, ██████████ ██████████, appeared on behalf of the Department of Community Health's (Department) Waiver Agency, the ██████████ ██████████, RN, Appellant's Nurse Supports Coordinator and ██████████ ██████████, Supports Coordinator Supervisor testified as witnesses for the ██████████ ██████████

**ISSUE**

Did the Waiver Agency properly deny an increase in 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 Medicaid beneficiary who is enrolled in the MI Choice Waiver program. (Exhibits A-D, Exhibit 1 and testimony).
2. The Appellant is a ██████-year-old woman (DOB ██████████). (Exhibit D, p. 1 and testimony).

3. On [REDACTED] LLMSW, Appellant's Supports Coordinator completed a [REDACTED] month reassessment of the Appellant to determine her continued need for services under the MI Choice Waiver Program. Appellant's services were continued at [REDACTED] hours per day, [REDACTED] days per week. Her services were being provided in [REDACTED] hour blocks, [REDACTED] m. and [REDACTED] days per week with [REDACTED] as the providing agency. (Exhibits B & D, p. 16 and testimony).
4. On [REDACTED], Supports Coordinator, [REDACTED], LBSW, sent the Appellant an Adequate Action Notice denying a request for an additional [REDACTED] hours of service [REDACTED] days per week, for the reason that Appellant's current services of [REDACTED] and [REDACTED] days per week with [REDACTED] are sufficient to meet her current needs. (Exhibit C and testimony).
5. On [REDACTED], Supports Coordinator, [REDACTED], LBSW, sent the Appellant an Amended Adequate Action Notice (to correct the misstated hours of service in the original notice) denying a request for an additional [REDACTED] hours of service seven days per week, for the reason that Appellant's current services of [REDACTED] and [REDACTED] days per week with [REDACTED] are sufficient to meet her current needs. (Exhibit B and testimony).
6. On [REDACTED], MAHS received the Appellant's request for an Administrative Hearing. (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 *Medicaid Provider Manual, MI Choice Waiver*, October 1, 2013, 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).

\* \* \*

### **2.3.B. REASSESSMENT OF PARTICIPANTS**

Reassessments are conducted by either a properly licensed registered nurse or a social worker, whichever is most appropriate to address the circumstances of the participant. A team approach that includes both disciplines is encouraged whenever feasible or necessary. Reassessments are done in person with the participant at the participant's home.

MI Choice uses a case status classification system to determine the reassessment and service plan review and the update schedule for program participants. Supports coordinators designate a case status for each participant at the time of service plan development or reassessment using professional judgment in determining participant needs.

Participants classified with active status are those individuals with the most difficult, unstable, or complex needs that require more intensive involvement. Supports coordinators classify participants as active when it is determined that the participant requires a reassessment every 90 days, or more frequently when necessary.

Participants classified with maintenance status are more physically stable and less complex than active cases. Monitoring is required less frequently. At the time of the second reassessment (180 days), the supports coordinator may designate the participant as on maintenance status. Subsequent to the second reassessment, the supports coordinator may designate maintenance status when the participant's situation is currently stable. The participant's level of frailty, risk, or illness determines that the participant requires a reassessment every 180 days or more frequently when necessary.

Supports coordinators may change the case status classification of participants as indicated upon reassessment. Regardless of a defined case status classification, participants may refuse reassessment. The supports coordinator must note this refusal in the case record. However, to maintain program eligibility, the supports coordinator must assess all program participants at least every 180 days. A refusal which prevents a redetermination within the 180-day window is cause for termination from the program. (p. 4).

\* \* \*

## **SECTION 4 – SERVICES**

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the current assessment;
  - detailed in the plan of service; and
  - provided in accordance with the provisions of the approved waiver.
- (p. 9).

\* \* \*

### **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).

#### **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).

The issue appealed is whether the Waiver Agency properly denied the Appellant's request for additional MI Choice Waiver services. Appellant's representative appealed the denial and stated she was asking for the Appellant to get more hours of service due to her condition, because she knows other people are getting more than six hours of services.

The Waiver Agency's witness Nurse ██████ testified there was a request for additional services for the Appellant and she asked a supervisor to go out and visit the Appellant for a follow-up, because there had been a change in staffing, to determine what needs were not being met and why there was a request for additional services. Nurse ██████ stated ██████ was the Supports Coordinator Supervisor who went out to do the follow-up visit with the Appellant.

Nurse ██████ stated that a six month reassessment had been done on ██████ by Supports Coordinator ██████. Nurse ██████ stated she did a new reassessment on ██████. The Appellant and her aide named ██████ were present for the reassessment. Nurse ██████ stated the Appellant was alert and oriented to time, date, and place, and there was no apparent cognitive impairment noted.

Nurse ██████ stated based upon her reassessment it was her professional opinion that the Appellant's current level of services would provide the care necessary for the Appellant's well-being. Nurse ██████'s opinion was that the Appellant's needs might be better met if

the █████ hours per day were split into █████ hour shifts rather than █████ hour shifts per day with the service times to be determined by the Appellant. Nurse █████ stated she was going to switch the Appellant from a maintenance status with █████ months reassessments to an active status with three months reassessments.

██████████ testified she was a social worker and was the supervisor for the Agency's supports coordinators. Ms. █████ stated she went out and met with the Appellant on █████. The Appellant told Ms. █████ she likes the hours of service she was receiving. Appellant also told Ms. █████ she liked the aides that were providing her services. The Appellant did not ask for any additional services. Ms. █████ stated the Appellant liked to nap between the time her aide left at █████ and the next one arrived at █████. Ms. █████ stated the Appellant had refused to have aides around at times and she likes to be left alone for her naps. Ms. █████ stated the Appellant's daughter █████ was present for the █████ visit. Ms. █████ also stated there is no guardianship over the Appellant.

Appellant's daughter testified she has concerns that the Appellant has memory problems. Appellant's daughter indicated her short term memory was good, but she might forget something by the next day. Appellant's daughter stated she wanted the Appellant to receive an extra hour of services at night. She testified that she wanted more time for the Appellant to digest her food and have a bowel movement before she went to bed.

Appellant's daughter testified she thought the Appellant's mental state and memory were going down fast. She testified the Appellant is sick a lot, she can't walk without assistance, she can't hear, and can't dial a phone. Appellant's daughter stated she knew the Waiver Agency couldn't provide care █████ and she was only asking for one additional hour of services per day.

When questioned by the Agency representative, Appellant's daughter had to admit that her mother's aides were able to get everything done within the time allowed for their services. She indicated her mother did not indicate to the Waiver Agents that she wanted additional services, but asked her later if she was going to get additional help. Appellant's daughter also acknowledged the Appellant had been on hospice and had an aide available to come in for an additional hour each day, but she refused to have the hospice aide come and assist her.

The Appellant bears the burden of proving by a preponderance of the evidence that additional MI Choice Waiver services are necessary. The Appellant was given an opportunity to prove why additional services are necessary. The testimony of the Appellant's witness did not establish the need for additional services for the Appellant above what the Waiver Agency determined were necessary in accordance with Medicaid policy. The preponderance of the evidence in this case shows that the services authorized are sufficient to meet the Appellant's current needs. Accordingly, the Agency's denial of additional MI Choice Waiver Services 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 acted properly when it denied Appellant's request for additional MI Choice Waiver services.

**IT IS THEREFORE ORDERED** that:

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

*William D Bond*

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William D. Bond  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/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.

