

**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. 2014-26537 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 aunt, appeared and testified on Appellant's behalf. Appellant and ██████████, Appellant's mother, also testified as witnesses for Appellant. ██████████ Clinical Manager, appeared and testified on behalf of the Department of Community Health's Waiver Agency, the ██████████ ("Waiver Agency" or ██████████). ██████████, social worker/case manager, also testified as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency properly decide to reduce Appellant's Community Living Supports?

FINDINGS OF FACT

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

1. ██████████ 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 in its service area.
2. Appellant is a ██████████ year-old Medicaid beneficiary who has been diagnosed with hypertension; peripheral vascular disease; arthritis; anxiety; depression; diabetes mellitus; and an antibiotic resistant infection. (Respondent's Exhibit E, pages 1, 7-8).
3. Appellant has been receiving services through the Waiver Agency, including ██████████ hours per week of Community Living Supports (CLS). (Respondent's Exhibit E, page 14; Testimony of ██████████; Testimony of ██████████).

4. The CLS are provided through two separate providers, with Appellant's mother providing █ hours per week through █ self-determination program and █, a care agency, providing the other █ hours per week. (Respondent's Exhibit E, page 14; Testimony of █; Testimony of █.
5. On █ staff conducted a reassessment of Appellant's services. (Respondent's Exhibit E, pages 1-14).
6. On █, following a review of Appellant's services, █, a registered nurse/case manager at █, telephoned Appellant's mother to discuss the services Appellant's mother was providing. (Respondent's Exhibit D, pages 2-3).
7. During that conversation, █ reiterated that the Waiver Agency can only pay for hands-on assistance and asked Appellant's mother to provide a time study of Appellant's needs and the hands-on care provided. (Respondent's Exhibit D, pages 2-3).
8. The time study was to be for the upcoming █ through █ and was to include the times of care, the care provided, and the time to complete the care. (Respondent's Exhibit D, page 2).
9. Appellant's mother then recorded the care provided by her husband, who had taken over as Appellant's self-determination CLS worker, for that weekend. (Testimony of █)
10. However, Appellant's mother testified that it was her understanding that she was to only identify either the times and tasks they charged the Waiver Agency for or the care provided during the day. (Testimony of █)
11. The document subsequently submitted by Appellant's mother to the Waiver Agency stated that Appellant was provided █ hours of care between █ and █. on █. (Respondent's Exhibit B, page 1).
12. The document also stated that Appellant was provided █ hours and █ minutes of care between █ and █ on █. (Respondent's Exhibit B, page 1).
13. The document further stated that Appellant was provided 3 hours of care between █. and █. (Respondent's Exhibit B, page 1).

14. Based on that time study, in addition to the presence of other informal supports that Appellant is receiving, the Waiver Agency decided to reduce Appellant's CLS from █████ hours per week to █████ hours per week. (Testimony of █████; Testimony of █████).
15. On ██████████ telephoned Appellant's mother to inform her of the reduction and the process for appealing that reduction. (Respondent's Exhibit D, page 2).
16. That same day, the Waiver Agency also sent Appellant written notice that her services were being reduced. (Respondent's Exhibit A, page 1).
17. Specifically, the notice stated that █████ self-determination hours and the █████ hours through ██████████ were being removed. (Respondent's Exhibit A, page 1).
18. The notice also provided that the effective date of the reduction would be █████ days from the date of the notice and that the "legal basis for this decision is 42CFR440.230(d)." (Respondent's Exhibit A, page 1).
19. On ██████████, the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant and her representative in this matter. (Petitioner's Exhibit 1, pages 1-2).
20. In that request, Appellant and her representative asserted that her physical condition has been deteriorating for years and she has only remained in her home because of the waiver services she receives. (Petitioner's Exhibit 1, pages 1-2).
21. Appellant and her representative also asserted that Appellant was never notified of the specific reason why the reduction was being made. (Petitioner's Exhibit 1, pages 1-2).
22. Due to the timing of the request for hearing, the Waiver Agency has not implemented the proposed reduction and will not do so while this appeal is pending. (Testimony of █████; 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, Skilled Nursing Facility, Intermediate Care Facility, or Intermediate Care Facility/Mentally Retarded. 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)

Here, as discussed above, Appellant has been receiving Community Living Supports (CLS) through ██████████ and the Waiver Agency now wants to reduce the amount of CLS she receives.

In her request for hearing, Appellant and her representative argue that the Waiver Agency's decision should be reversed both because Appellant failed to receive proper notice of the reduction and because the previous amount of hours authorized is still medically necessary.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in deciding to reduce her services. Moreover, this Administrative Law Judge is limited to reviewing the Waiver Agency's decision in light of the information it had at the time it made that decision.

Each of Appellant's arguments will be addressed in turn and, for the reasons discussed below, this Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that the Waiver Agency's decision must be affirmed.

Notice

Appellant and her representative first argue that the proposed reduction in this case should be reversed because Appellant never received proper notice of the decision to reduce Appellant's services.

With respect to the notice required for negative actions in the MI Choice Program, the applicable version of the Michigan Medicaid Provider Manual (MPM) states:

SECTION 11 - APPEALS

The Michigan Department of Community Health has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E of the Code of Federal Regulations. Provider appeal rights conform to the requirements of Michigan law and rules found at MCL 400.1 et seq. and MAC R 400.3401 et seq.

11.1 PARTICIPANT APPEALS

MI Choice has established notice and appeals requirements to which waiver agencies must adhere when adverse action has been taken for program applicants or participants. According to 42 CFR 431.201 "Action" means a termination, suspension, or reduction of Medicaid eligibility or of covered services.

* * *

11.1.B. ADVANCE ACTION NOTICES

An Advance Action Notice must be sent to MI Choice participants when action is being taken to reduce, suspend, or terminate service(s) a participant currently receives. This notice must be provided at least 12 days in advance of the intended action.

An Advance Action Notice is also issued if it is determined that a reduction in level or number of services is warranted based on the participant's current assessment. The notice must inform the participant that services will not be reduced until a formal decision has been rendered through the Medicaid Fair Hearings process if the participant formally requests a hearing before the specified date of the intended action.

11.1.C. NOTICES

Advance Action Notices and Adequate Action Notices that relate to the LOCD process are posted on the MDCH website. (Refer to the Directory Appendix for website information.)

Waiver agencies may use additional notices for actions not related to the LOCD process. These notices must be approved by MDCH prior to use to assure compliance with 42 CFR 431.210. Waiver agencies must supply a copy of the Request for Hearing form (DCH-0092) and a return envelope with each notice sent to an applicant or participant, or any time an applicant or participant requests such material. Waiver agencies are required to assist applicants or participants who request help in filing an

LOCD exception review through the Michigan Peer Review Organization (MPRO), or a formal appeal for any reason through the Medicaid fair hearings process.

*MPM, January 1, 2014 version
MI Choice Waiver Chapter, pages 34-35*

Moreover, the section of the Code of Federal Regulations (CFR) referenced in the above policy, 42 CFR 431.210, regarding the contents of a notice, states:

A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—

(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

42 CFR 431.210

Here, the written notice sent by the Waiver Agency provided that █████ self-determination hours and the █████ hours through █████ were being removed; the effective date of the reduction would be █████ days from the date of the notice; and the legal basis for the decision was 42 CFR 440.230(d). (Respondent's Exhibit A, page 1).

Therefore, despite Appellant's representative's claims to the contrary, the notice of reduction did identify the legal basis for the reduction. Moreover, while not expressly clear, the reason for the intended action becomes clearer if Appellant or her representative had examined the legal basis identified in the notice. That legal basis,

42 CFR 440.230, regarding the sufficiency of amount, duration and scope of services, states:

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 CFR 440.230 (emphasis added)

Also, to the extent the notice failed to expressly identify the reasons for the intended action, that error is harmless in this case as the reduction has not been implemented and the reason for the reduction was elaborated on in both verbal discussions and the hearing summary provided prior to the hearing.

Accordingly, the undersigned Administrative Law Judge finds that the Waiver Agency's decision should not be reversed in this case due to any defective notice.

Reduction

With respect to the CLS Appellant has been receiving, the applicable version of the 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.

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 continually been authorized for such services. Instead, the sole dispute is the amount of CLS hours to be authorized, with the Waiver Agency deciding to reduce Appellant's CLS from █ hours per week to █ hours per week and Appellant wanting her services to remain at their previous level.

According to the Waiver Agency's witnesses, it decided to reduce Appellant's CLS because of the information reported it to by Appellant's parents, especially the time study indicating that Appellant was only receiving █ to █ hours of hands-on care per day. It also noted that Appellant has other informal supports to assist her and that, per policy, the Waiver Agency is the payor of last resort.

In response, Appellant and her witnesses testified that Appellant needs all of the care she has been receiving. Moreover, regarding the time study, Appellant and her witnesses testified that the document Appellant's mother provided was inaccurate and incomplete with respect to Appellant's services. Specifically, Appellant's mother testified that she was confused as to what she was to record for the time study and that she thought she was only supposed to write down either the tasks being charged to the agency or the assistance provided during the day, as opposed to the assistance provided both day and night.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in deciding to reduce her services. Moreover, this Administrative Law Judge is limited to reviewing the Waiver Agency's decision in light of the information it had at the time it made that decision.

In this case, given the information available at the time the Waiver Agency made its decision, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proving that the Waiver Agency erred and █ decision to reduce Appellant's CLS must be affirmed.

The time study submitted by Appellant's provider clearly states that Appellant only received █ hours of care a day and that time study, which was submitted by Appellant's provider, was justifiably relied upon by the Waiver Agency. After the reduction, Appellant will still be receiving █ hours of CLS each day and that amount appears appropriate, especially given the presence of significant informal supports, including whichever of Appellant's parents is not her formal CLS worker.

Moreover, while Appellant and her witnesses claim that confusion led to an inaccurate or incomplete report, their claims are not credible. For example, even if Appellant's mother believed that she was only supposed to document the services provided during

the day, as opposed to both day and night, it makes little sense that the time study would end in the early afternoon if Appellant was receiving all of the care she claimed to be receiving. Similarly, even if Appellant's mother believed that she was only supposed to document the care being charged to the agency, the amount of care provided during the blocks of time appears low given the significant amount of CLS that was authorized and, if that is all the time Appellant needs formal supports for, the Waiver Agency was still justified in reducing her services.

To the extent Appellant's circumstances change or she has updated or additional information to provide, she can always request additional waiver services in the future. With respect to the decision at issue in this case, however, the Waiver Agency's actions are affirmed given the information available at the time it made its decision.

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 to reduce Appellant's services.

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]


Docket No. 2014-26537 EDW
Decision and Order

***** 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.