

**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:**

██████████,

Appellant

\_\_\_\_\_ /

**Docket No.** 2014-34663 EDW

**Case No.** ██████████

**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 ██████████. Appellant appeared and testified. ██████████, appeared as witnesses for Appellant.

██████████, Clinical Manager, and ██████████, Social Worker Supports Coordinator, appeared on behalf of the Department's Waiver Agency, ██████████ on ██████████ of ██████████, Michigan (Agency or Waiver Agency).

**ISSUE**

Did the Waiver Agency properly deny Appellant's request for an increase in MI Choice 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 Department contracts with the Waiver Agency to provide MI Choice Waiver services to eligible beneficiaries.
2. The Waiver Agency must implement the MI Choice Waiver program in accordance with Michigan's waiver agreement, Department policy and its contract with the Department.
3. Appellant is a ██████ year-old Medicaid beneficiary. Appellant's diagnoses include COPD, peripheral vascular disease, arthritis, stroke/CVA. (Exhibit A.8)

4. On ██████████ the Agency conducted an assessment and entered the following progress notes: Appellant receives in home skilled nursing care by a nurse who is required to provide a bath aid, and bathing 2-3 baths per week with a bath aid. Appellant also receives Mom's Meals 14 meals per week, liquid supplements of 60 per months, and a PERS button. (Exhibit A.3)
5. Appellant is approved 3 hours per week of IADL assistance in the MI Choice program. (Exhibit A.3)
6. On ██████████, Appellant requested an increase in hours.
7. On ██████████, the Agency issued a denial of service request for increased hours.
8. ██████████, the Michigan Administrative Hearing System received a request for hearing from the Appellant.

### **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*, 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*  
*April 1, 2013, pp 12-13*

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, are the last resort, and therefore Medicaid-covered, the Waiver Agency performs periodic assessments.

Appellant bears the burden of proving, by a preponderance of evidence, to show that she has eligibility for her request, which in this case, is for an increase in hours.

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In this case, Appellant first argued that the Agency decreased her hours. However, credible and substantial evidence of record established that there has been no decrease.

Appellant next argued that the skilled care she is receiving informed her that they do not have enough staff to bathe her. However, the Agency pointed out that it cannot be held responsible for the actions or in actions of the skilled nurse. If the Agency were to grant Appellant bathing hours, the Agency would NOT be paid as it is a service already being provided by the skilled nursing arrangement. This Agency is a payor of LAST RESORT. If Appellant is already getting the services, or if they are already approved by a different agency, federal and state law does not allow duplication. The Agency herein did indicate that Appellant's contract with the skilled nurse evidently contains procedures for Appellant to complain or appeal the services being provided. Such requests are not filed with this Agency, or reviewed by this forum.

At the same time, the Agency here in indicated that if and when Appellant's contract with the skilled nurse facility ends, at that time MI Choice Waiver may pick up these care needs as such would not be a duplication of services.

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.

After a careful review of the credible and substantial evidence on the whole records, this ALJ finds that the Department's actions were in compliance with its policy, and supported by the documentary and testimonial evidence taken as a whole. Appellant's arguments were not supported by any evidence or authority that would sufficiently rebut the Department's evidence. As to any new medical issues, Appellant may request another increase; however, this review must focus on the evidence in existence at the time the Agency made its determination.

In addition, as noted above, Appellant must present evidence that meets a preponderance of evidence standard that what she is requesting is medically necessary, and, that the Agency be the payor of the last resort. Medicaid covered services. *42 CFR 440.230*. Moreover, ICLS 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. *Medicaid Provider Manual MI Choice Waiver Section, April 1, 2013, pp 12-13*.

This ALJ finds that Appellant does not meet this standard and thus, the Agency's actions are upheld.

**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 an increase in MI Choice Waiver hours.

**IT IS THEREFORE ORDERED** that:

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

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Janice Spodarek  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

JS [REDACTED]

cc: [REDACTED]

Date Signed: [REDACTED]

Date Mailed: [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.