

**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. 2014-8463 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 Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on his own behalf.

██████████, RN, Contracts Manager, appeared and testified on behalf of the Department's Waiver Agency, ██████████ (██████████ or Waiver Agency). ██████████, RN, Supports Coordinator and ██████████, LBSW, Supports Coordinator, appeared as witnesses for the Waiver Agency.

**ISSUE**

Did the Waiver Agency properly reduce Appellant's Community Living Supports (CLS) hours from 21 to 13 hours per week?

**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 ██████████ to provide MI Choice Waiver services to eligible beneficiaries. (Testimony)
2. ██████████ 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, born ██████████. Appellant's diagnoses include cervical disc degeneration, coronary heart disease, chronic obstructive pulmonary disease (COPD), hypertension, seizure disorder, anxiety, depression, cancer, hyperthyroidism, asthma,

thinitis, generalized pain, and hypercholesterolem. (Exhibit A, p 14; Testimony)

4. Appellant lives alone in his own apartment. Appellant's informal supports consist of his son and sister. (Exhibit A, p 9; Testimony)
5. A home visit for a reassessment was completed on ██████████. (Exhibit A, pp 7-21; Testimony)
6. Following the reassessment, a new Care Plan Worksheet was prepared, which demonstrated that Appellant only meet the medical necessity criteria for 13 CLS hours per week. (Exhibit A, pp 4-6).
7. On ██████████, ██████████ notified Appellant that it had determined that his CLS hours would be reduced from 21 to 13 hours per week. (Exhibit A, p 3; Testimony).
8. On ██████████, the Michigan Administrative Hearing System received a request for hearing from the Appellant. (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)*

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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*, October 1, 2013, 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*  
*October 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, and therefore Medicaid-covered, the Waiver Agency performs periodic assessments.

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Appellant bears the burden of proving, by a preponderance of evidence, that 21 hours per week of CLS hours are medically necessary.

The Waiver Agency Witnesses testified that the new Care Plan Worksheet completed during the September 2013 assessment showed that Appellant's medically necessary needs could be met in 13 hours per week. The Waiver Agency Witnesses indicated that Appellant also receives 9 home delivered meals per week and that the Department of Human Services (DHS) should be providing Appellant's medical transportation. The Waiver Agency Witnesses also indicated that during the period prior to the assessment, Appellant's aides were often being sent home early because Appellant did not have enough for them to do.

Appellant testified that his needs were barely being met when he was receiving 21 CLS hours per week and that he needs more hours for errands and appointments, pharmacy, grocery store, doctors, and also food banks. Appellant indicated that he cannot move around very well, stand for a long time, or use his hands. Appellant testified that he lives alone with limited help and now has extra medical appointments because of his cancer treatments. Appellant indicated that he did send his workers home when he was sick because he was just lying in bed so there was not much for them to do. Appellant testified that he needs more CLS hours so that his aides can accompany him to doctor's appointments to help him with the paperwork, which he cannot fill out because of problems with his hands. Appellant also indicated that he has been having trouble getting transportation through DHS because they need to be notified so far in advance. Appellant indicated that he is now doing much worse than he was back in [REDACTED] when this assessment was completed.

The Waiver Agency Witnesses indicated that Appellant is due for another assessment in [REDACTED], and they will certainly reevaluate his needs at that time.

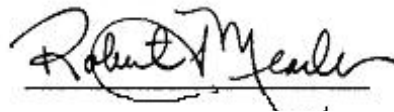
This ALJ finds that the Waiver Agency properly reduced Appellant's CLS hours from 21 to 13 per week. Appellant failed to prove, by a preponderance of the evidence, that 21 CLS hours per week were medically necessary. The Waiver Agency properly assessed Appellant's needs and determined through a detailed Care Plan Worksheet that Appellant's actual needs can be met in 13 CLS hours per week. Appellant offered no testimony to dispute the findings contained in the Care Plan Worksheet. While Appellant's condition may have worsened since that time, this ALJ can only base his decision on the information the Waiver Agency had when it made its decision back in [REDACTED]. As such, the reduction in Appellant's CLS hours was proper.

**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 reduced Appellant's CLS hours from 21 to 13 hours per week.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.



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

cc:

[REDACTED]

Date Signed: February 20, 2014

Date Mailed: February 20, 2014

**\*\*\* 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.