

3. On ██████████ was notified that Appellant's Medicaid was approved retroactive to ██████████. (Exhibit A, pp. 1, 15 and testimony).
4. On ██████████, a ██████-day reassessment was conducted with the Appellant and her sister, by ██████████ LLMSW, Supports Coordinator and Care Manager, in the Appellant's home. ██████████ determined that the Appellant was eligible for ██████ hours of personal care and ██████ hours of homemaker services per week. DHS approved a total of ██████ hours per week of homemaking services and personal care for the Appellant effective ██████████. (Exhibit A, pp. 1-2, 5, 30-31 and testimony).
5. Appellant advised that her niece had been providing services back to ██████████ and requested compensation for ██████ hours per week back to that date. The request for retroactive authorization of ██████ hours back to ██████████ was denied because the Appellant was initially authorized for only ██████ hours per week of personal care and ██████ hours per week of homemaking services. (Exhibit A, pp. 1, 2, 5, 31 and testimony).
6. On ██████████, an Adequate Action Notice was sent to the Appellant stating effective ██████████ she was approved a total of ██████ hours per week of homemaking services and personal care. Testimony given by the Waiver Agents at the hearing clarified that the Appellant was retroactively approved for the for ██████ hours per week of personal care and ██████ hours per week of homemaking services approved back on ██████████. (Exhibit A, p. 2 and testimony).
7. On ██████████, MAHS received the Appellant's request for an Administrative Hearing. (Exhibit A, p. 3).

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].

* * *

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.

Services must not be provided unless they are defined in the plan of service and must not precede the establishment of a plan of service. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider.

MDCH and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDCH and waiver agencies do not impose a premium, enrollment fee, or similar costsharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider, thereby assuring freedom of choice.

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, emphasis added].

* * *

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, emphasis added].

The issue appealed is whether the Waiver Agency properly denied retroactive payment for ████████ hours of MI Choice Waiver services back to ██████████. Appellant was enrolled in the MI Choice Waiver program on ██████████. At that time Appellant was eligible for ████████ hours per week of personal care and ████████ hours per week of homemaking services, based on the initial assessment completed by ██████████, LLBSW and ██████████ RN.

(Exhibit B). The Waiver Agency was advised on [REDACTED] by the Appellant's authorized representative that the waiver services had not started because Appellant's Medicaid Application had been denied. Thereafter on [REDACTED] Appellant's Medicaid was approved following an administrative hearing, retroactive to [REDACTED].

The Waiver Agency's witnesses testified a [REDACTED]-day reassessment for MI Choice Waiver services was conducted on [REDACTED] with the Appellant and her sister, by [REDACTED] LLMSW, Supports Coordinator and Care Manager, in the Appellant's home. [REDACTED] determined that the Appellant was eligible for [REDACTED] hours of personal care and [REDACTED] hours of homemaker services per week. The Waiver Agency approved a total of [REDACTED] hours per week of homemaking services and personal care for the Appellant effective [REDACTED].

The Waiver Agency was advised by Appellant that her niece had been providing services back to [REDACTED] and requested compensation for [REDACTED] hours per week back to that date. The request for retroactive authorization of [REDACTED] hours back to [REDACTED] was denied because the Appellant was initially only authorized for [REDACTED] hours per week of personal care and [REDACTED] hours per week of homemaking services.

Appellant's representative testified the Appellant was enrolled in the [REDACTED] because they could make up the hours the Appellant would need for home care when Medicaid did not have enough funds to provide the care. The Appellant's representative claimed that they were told back in [REDACTED] that the Appellant would receive [REDACTED] hours of services from the Waiver Program. She stated that the Appellant was considered to be legally blind and has a heart condition. Appellant's representative does not believe that the [REDACTED] hours authorized in [REDACTED] was enough to provide care for the Appellant. Exhibit B, the [REDACTED] initial assessment, was obtained and admitted into the record in order to establish the Appellant's condition at that time, presumably to compare it with the Appellant's condition as assessed on [REDACTED]. Appellant's representative urged that the Appellant's condition had not changed and that she should have been approved for [REDACTED] hours of combined homemaking and personal care services back in April, the same as was determined at the [REDACTED] reassessment.

The Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency did not act properly in denying her request for retroactive payment for [REDACTED] hours of MI Choice Waiver services back to [REDACTED]. The testimony of the Appellant's representative did not establish that the Waiver Agency acted improperly when it denied retroactive payment for more than the [REDACTED] hours of combined homemaking and personal care services that were initially authorized for the Appellant back on [REDACTED]. The Waiver Agency acted in accordance with the Medicaid policy quoted above. The Waiver Agency cannot provide retroactive payment for waiver services that the Appellant was not found to be eligible for in [REDACTED]. As stated in policy the services are based on the current assessment and must be defined in the plan of service prior to them being provided to the Appellant. Furthermore, the current appeal is not a timely appeal of the determination made back in [REDACTED] concerning whether the services authorized at that time were sufficient to meet the Appellant's individual needs.

[REDACTED]
Docket No. 2014-9672 EDW
Hearing Decision & Order

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 retroactive payment for [REDACTED] hours of MI Choice Waiver services back to [REDACTED]

IT IS THEREFORE ORDERED that:

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

William D Bond

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.

