

**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.** 2014-9673 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 a request for a hearing filed on behalf of the Appellant/Petitioner.

After due notice, a hearing was held on ██████████, along with attorney ██████████, appeared on Appellant's behalf. ██████████, Appellant's legal guardian/conservator, testified on Appellant's behalf. ██████████, Clinical Manager, appeared and testified on behalf of the Department of Community Health's Waiver Agency, ██████████ ("Waiver Agency" or "██████████"). ██████████, Care Manager/Supports Coordinator, also testified as a witness for the Waiver Agency.

Following the hearing, the record was left open for ██████████ weeks so the parties could submit closing briefs.

**ISSUE**

Did the Waiver Agency proper deny Appellant's request for additional Community Living Supports (CLS) through the MI Choice waiver program?

**FINDINGS OF FACT**

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

1. Appellant is a ██████████ year-old female who has been diagnosed with Huntington's disease; anxiety; and schizophrenia. Appellant also has a history of skin cancer. (Petitioner's Exhibit 9, page 2; Respondent's Exhibit D, pages 7-8).
2. On ██████████, an Irrevocable OBRA '93 Under 65 Disability Payback Trust was created for the benefit of Appellant. (Petitioner's Exhibit 9, pages 1-36).

3. In the trust document, it was specifically noted that Appellant was receiving both Social Security Disability Insurance (SSDI) and Medicare benefits, and that it was not the intent of the trust to jeopardize her continuing eligibility for government benefits. (Petitioner's Exhibit 9, page 2).
4. Instead, the stated intent of the trust was to supplement those benefits and to allow Appellant to qualify for Medicaid under current regulations. (Petitioner's Exhibit 9, page 2).
5. The same day the trust was created, Appellant's attorney contacted ██████████ about services through the MI Choice Waiver Program. (Respondent's Exhibit E, page 9).
6. ██████████ 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.
7. Appellant's attorney informed ██████████ that a special needs trust had been set up and that Appellant was losing a caregiver on ██████████. Appellant's attorney also requested that an exception be made and Appellant be moved up the wait list for waiver services. (Respondent's Exhibit E, page 9).
8. An ██████████ staff member contacted ██████████ at the MDCH and learned that Appellant did not have Medicaid coverage. (Respondent's Exhibit E, page 9).
9. The staff member then contacted Appellant's attorney to recommend that Appellant complete an application for Medicaid and to inform him that services through the local Community Mental Health (CMH) agency could be an option. (Respondent's Exhibit E, page 9).
10. On ██████████ the Michigan Department of Human Services (DHS) issued a Notice of Case Action stating that Appellant was approved for Medicaid coverage, with an effective start date of ██████████. (Petitioner's Exhibit 7, pages 1-6).<sup>1</sup>
11. On ██████████, Appellant's attorney contacted ██████████ to inform it of the Medicaid approval and to request an assessment. (Respondent's Exhibit E, page 9).
12. On ██████████, an Imminent Risk Assessment was performed in Appellant's home. (Respondent's Exhibit E, pages 7-8).

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<sup>1</sup> The Notice of Case Action also provided that Appellant's request for Medicaid was denied for the time period of ██████████ through ██████████. (Petitioner's Exhibit 7, page 1).

13. During that assessment, it was noted that the trust was paying for there to be caregivers with Appellant (██████████) hours a day, but that the money was running out. (Respondent's Exhibit E, pages 7-8).
14. ██████ also found that Appellant scored a "7" on the Imminent Risk Assessment Tool and therefore did not qualify for nursing facility diversion priority status on the MI Choice waiting list. (Respondent's Exhibit E, pages 7-8).
15. On ██████████, Appellant's attorney telephoned the Waiver Agency to question the imminent risk score and to again request that Appellant be moved up the wait list. (Respondent's Exhibit E, page 7).
16. On ████████████████████ from the MDCH telephoned the Waiver Agency to inform it that the Department had conducted a review of the case and was requesting that Appellant be put through as a diversion priority due to Appellant's cognitive issues. (Respondent's Exhibit E, page 7).
17. On ██████████, the Waiver Agency opened Appellant's case and scheduled an assessment. (Respondent's Exhibit E, page 7).
18. That assessment for services, as well as another imminent risk assessment, was performed on ████████████████████ in Appellant's home. (Respondent's Exhibit D, pages 1-15; Respondent's Exhibit E, page 6).
19. During that home visit, ██████ staff determined that Appellant scored a "10" on the Imminent Risk Assessment Tool due to the fact that she had recently lost two caregivers. (Respondent's Exhibit D, page 4; Respondent's Exhibit E, page 6).
20. The ██████ staff also determined that Appellant qualified for waiver services by passing through Door 1 of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). (Respondent's Exhibit E, page 6).
21. With respect to Appellant's needs for assistance, it was noted that Appellant is totally dependent on others in the areas of meal preparation, housework, managing finances, managing medications, going up stairs, transportation, eating, personal hygiene, bathing. (Respondent's Exhibit D, pages 11-13).
22. Appellant was also found to require extensive assistance with dressing and limited assistance with transferring and toilet use. (Respondent's Exhibit D, pages 11-13).

23. Appellant was further found to require supervision when walking or using the telephone. (Respondent's Exhibit D, pages 11-13).
24. The assessment also noted that the required assistance was being provided by care workers paid for by the trust, with services being provided █ hours a day, █ days a week. (Respondent's Exhibit D, page 4; Respondent's Exhibit E, page 6).
25. Appellant's guardian also provided some assistance, such as managing Appellant's finances. (Respondent's Exhibit D, page 4; Respondent's Exhibit E, page 6).
26. At the time of the assessment, Appellant's guardian was requesting twenty █ hours a day of Community Living Supports (CLS) through █ Self Determination Program. (Respondent's Exhibit E, page 6; Testimony of █)
27. However, the █ staff only indicated that it would start at █ hours a week of CLS and that any authorization was contingent on their supervisor's approval. (Petitioner's Exhibit 1, page 1; Respondent's Exhibit E, page 6).
28. █ also agreed to start providing a Personal Emergency Response System (PERS) unit and to initiate a person centered plan (PCP). (Respondent's Exhibit E, page 6).
29. Even after Appellant started receiving services through █, the trust continued to pay for care workers to provide assistance with Appellant █ hours a day. (Testimony of █)
30. On █ from █ met with Appellant's guardian to complete some paperwork relating to the Self Determination Program. (Respondent's Exhibit E, page 4).
31. At that time, Appellant's guardian asked about more CLS hours for Appellant and was told that more hours could be requested through Appellant's case manager after the PCP was completed. (Respondent's Exhibit E, page 4).
32. Appellant's guardian then signed a Self Determination Budget Worksheet indicating that Appellant was approved for █ hours of CLS per week, divided among two care workers. (Respondent's Exhibit B, page 1).
33. On █ of the █ County Probate Court issued an Order Granting the Petition for Approval of an OBRA 93 Disability Payback Trust. (Petitioner's Exhibit 2, pages 1-3).

34. On ██████████, Appellant's guardian and Julie Karbginsky, Appellant's case manager, held a PCP meeting. (Respondent's Exhibit E, page 3).
35. During that meeting, Appellant's guardian requested ██████ hours a day, █ days a week, of CLS services. She also noted that Appellant's conditions are getting to the point where she cannot be left home at all. (Respondent's Exhibit E, page 3).
36. ██████████ agreed to submit the request. (Respondent's Exhibit E, page 3).
37. The request for additional hours was reviewed and it was determined that it should be denied on the basis that Appellant is only authorized to receive what is medically necessary. (Respondent's Exhibit E, page 3; Testimony of ██████████ Testimony of ██████████)
38. In making that decision, ██████ took into account the fact that, in addition to the █ hours per week provided through the Waiver Agency, Appellant is also receiving care paid for by the trust. (Testimony of ██████████; Testimony of ██████████).
39. ██████ staff also told Appellant's guardian that the trust would have to be exhausted before the Waiver Agency would provide the services the trust has been paying for. (Testimony of ██████████)
40. On ██████████ sent Appellant's guardian written notice that the request for █ hours a day, █ days a week, of CLS services was being denied on the basis that the "assessment/reassessment does not support need for service. (Respondent's Exhibit F, page 1).
41. On ██████████, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed on Appellant's behalf and regarding that denial of additional hours.
42. After due notice, a hearing was held on ██████████.
43. Following the hearing, the record was left open for ██████ weeks so the parties could submit closing briefs.

### **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, SNF [Skilled Nursing Facility], ICF [Intermediate Care Facility], or ICF/MR [Intermediate Care Facility/Mentally Retarded], and is reimbursable under the State Plan. See 42 CFR 430.25(c)(2).

Types of services that may be offered generally 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)*

Among the specific services approved in this case are Community Living Supports (CLS). With respect to such services, the applicable version of the Michigan Medicaid Provider Manual (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.

*MPM, October 1, 2013 version  
MI Choice Waiver Chapter, pages 12-13*

However, while CLS are Medicaid-covered services, Medicaid beneficiaries are still only entitled to medically necessary covered services for which they are eligible and services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. See 42 CFR 440.230.

Here, it is undisputed that, due to her medical needs, Appellant requires more than the █████ hours per week of CLS authorized by the Waiver Agency.

The Waiver Agency nonetheless declined to authorize more hours of CLS on the basis that Appellant is already receiving other care services paid for by a trust and that Appellant's medical needs can be met through the combination of CLS and services through the trust. According to the █████ representative, the Waiver Agency must take all available services and funds into account when authorizing services, and that the Waiver Agency is the payor of last resort.

Appellant's representative argues in response that the Waiver Agency erred by taking the services paid for by the trust into account as those funds are discretionary; temporary; only meant to supplement Appellant's services through Medicaid and the

Waiver Agency; and were specifically excluded from the determination of Appellant's assets when determining Appellant's financial eligibility.

For the reasons discussed below, this Administration Law Judge agrees with Appellant's interpretation of the relevant policy and finds that the Waiver Agency erred. ██████ cannot take the temporary services paid for by the trust into account when considering the amount of medically necessary services it is required to provide.

In support of its position, the Waiver Agency primarily relies on the Minimum Operating Standards for MI Choice Waiver Program Services and, as provided in the MPM, such standards do apply in this case:

#### **4.5 OPERATING STANDARDS**

MDCH maintains and publishes the "Minimum Operating Standards for MI Choice Waiver Program Services" (known as the Minimum Operating Standards) document. This document defines both general and specific operating criteria for the program. All waiver agencies and service providers are subject to the standards, definitions, limits, and procedures described therein.

For each service offered in MI Choice, the Operating Standards are used to set the minimum qualifications for all direct service providers, including required certifications, training, experience, supervision, and applicable service requirements. Billing codes and units are also defined in the document.

*MPM, October 1, 2013 version  
MI Choice Waiver Chapter, page 17*

Specifically, the Waiver Agency relies on portions of Attachment I of the Minimum Operating Standards:

#### **IV. SUPPORTS COORDINATION**

SC is the method that facilitates access to and arrangement of services and other forms of support needed and wanted by MI Choice participants. SCs work with participants to determine how and who will meet the participant's LTC needs. SCs assist participants in arranging for services and supports and monitor the quality of services received. SC includes valuing the cultural backgrounds of participants in the decision making process.

## **A. DEFINITION**

SC is a service designed to inform, assist, and coordinate a variety of home and other community-based services needed by elderly and other adults with disabilities aged 18 years and older who meet the NFLOC. SCs utilize all available services and supports before authorizing MI Choice services while assisting the participant in planning interventions. SCs work in partnership with participants to determine the interventions that will promote the participant's goals and facilitate the achievement of desired outcomes while addressing the participant's service and support needs.

SCs build participant choices and preferences into the SC process to assure a person focused, self-determination approach to the receipt of services and supports. SCs arrange formal services based upon participant choice and approval. The participant and their SCs explore other funding options and intervention opportunities when personal goals expand beyond meeting basic needs.

## **B. SUPPORTS COORDINATION SERVICE FUNCTIONS**

SCs provide all of the following functions:

### **1. Assessment**

The iHC Assessment System, consisting of the iHC and CAPs, is the basis for the MI Choice Assessment. SCs perform a comprehensive evaluation including assessment of the individual's: unique preferences; physical, social, and emotional functioning; medication; physical environment; natural supports; and financial status. The SC must fully engage the participant in the interview to the extent of the participant's abilities and tolerance.

Specific iHC items identify applicants who could benefit from further evaluation of particular problems and risks for functional decline. These items, called "triggers," link the iHC to a series of problem oriented CAPs. The CAPs are procedures that guide the SCs through further assessment and individualized service and support planning with participants.

## **2. Plan of Service Development**

SCs and participants plan interventions from both allies and community resources that will meet each participant's identified needs. A written plan of service documents the issues, concerns, conditions, and specific supports and interventions needed. The SC and participant base the plan of service upon participant preferences and needs identified during a PCP assessment process.

\* \* \*

## **D. INVOLVEMENT OF ALLIES**

SCs work with participants to engage a team of family, friends, professionals, supports brokers, caregiver staff, and other allies to assist in the development of plans of service and to strengthen the skills of participants to address planned activities. Generally, MI Choice services are not used to replace existing unpaid supports, but rather bolster and help sustain ongoing allies' involvement.

## **E. USE OF OTHER PAID SERVICES**

Before authorizing MI Choice services for a participant, the waiver agency must take full advantage of services and supports in the community that are available to the participant and paid for by other fund sources, including third party reimbursements and the Medicaid State Plan services. MI Choice funding is the payment source of last resort. Two exceptions are Physical Disability Services (PDS) funds and OSA in-home services funds. These are extremely limited fund sources and would be quickly exhausted if used for MI Choice participants. (Note: An executive order cut PDS funds from the FY 2010 budget. MDCH does not expect the Governor to reinstate these funds for FY 2014.)

## **F. THIRD PARTY LIABILITY (TPL)**

The waiver agency pursues and secures all TPL sources possible. Waiver agencies make every effort to enroll and utilize dually certified Medicare/Medicaid providers for counseling, training, private duty, and nursing services to maximize Medicare payment for services also available

through MI Choice. Other TPL sources include the Veteran's Administration, Medicare skilled home health services, the Medicaid State plan, and other sources of LTC available to participants.

*Minimum Operating Standards for MI Choice Waiver Program Services, Attachment F, FY 2014, pages 14-15, 49*

The above standards relied upon by the Waiver Agency therefore do generally provide that MI Choice funding is the payment source of last resort and that the Waiver Agency must first take full advantage of other services and supports in the community that are available to Appellant and paid for by other fund sources, including third party reimbursements. Additionally, the above policy provides that MI Choice services may only bolster and sustain unpaid supports from allies.

However, even considering that language, the above policy does not support the Waiver Agency's broad position that it properly considered and refused to replace temporary services Appellant was already receiving, regardless of whether the services are being paid for by discretionary private funds.

The funds at issue in this case are not available in the community and, instead, are discretionary funds from a trust specifically designed to supplement the government benefits that Appellant was already receiving and might receive in the future.

Moreover, the only types of third parties or available payors specifically identified by the above policy are Medicare; Medicaid; the Veteran's Administration; Medicare skilled home health services; and the State plan; all of which are government programs rather than discretionary, temporary funds paid out of a trust.

As determined by DHS and the ██████████ County Probate Court, the Trust was properly established under the law and it did not affect Appellant's financial eligibility for Medicaid or the MI Choice Waiver program. Both Medicaid itself and the MI Choice Waiver program are entitlement programs, and Appellant, who qualifies for both, is therefore entitled to all medically necessary services available through the waiver program. The mere fact that the Trust, which was only designed to supplement those services, was temporarily paying for necessary support while CLS was being put in place does not render more services unnecessary and additional CLS would not be duplicating any services that Appellant is authorized for.

Accordingly, this Administrative Law Judge finds the Waiver Agency's argument and reliance on the above policy to be unpersuasive with respect to the Waiver Agency's claims that it need not provide all the necessary services simply because some of those services are being temporarily paid for, by choice, by a trust.

The Waiver Agency also submitted its Community Support Services Participant Handbook as an exhibit. However, that Handbook is not governing policy and, to the extent that it is even relevant, it only states that “MI Choice funding is considered funding of last resort and may not, under any circumstance, be used to replace services a person is entitled to under Medicare, under Medicaid Skilled Care or Medicaid State Plan.” (Respondent’s Exhibit H, page 2). No such services through the government at issue in this case and, if anything, the Handbook only confirms that discretionary payments from a trust are not to be considered as a higher priority funding source when authorizing waiver services.

Nor do other portions of the MPM or the Minimum Operating Standards not cited to by ██████████ support the Waiver Agency’s broad position. For example, the MPM does not refer to informal or discretionary supports. Instead, it merely references existing State Plan or other services without suggesting that discretionary payments from a trust, or any third-party for that matter, must also be considered by the Waiver Agency. See MPM, October 1, 2013 version, MI Choice Waiver Chapter, pages 1, 3, 16.

Similarly, while Attachment F of the Minimum Operating Standards, regarding the limitations on self-determined service delivery of CLS, also provides that a participant must use Medicaid state plan, Medicare, or other available payers before the Waiver Agency, the focus of the limitations is on other government benefits that a participant may be entitled to and there is no suggestion that other available payers includes discretionary payments from a trust specifically created to supplement government benefits. See Minimum Operating Standards for MI Choice Waiver Program Services, Attachment F, FY 2014, pages 22-23.

Therefore, for the reasons discussed above, this Administrative Law Judge finds the Waiver Agency erred in considering Appellant’s temporary services through the trust when determining how much CLS was medically necessary and should be authorized.

It is not clear from the record how many hours should be authorized, so this Administrative Law Judge will only order that the Waiver Agency reassess Appellant’s services and medical needs. In doing so, the Waiver Agency may not take into account or refuse to grant additional services on the basis that Appellant is already receiving discretionary and temporary services paid for by the trust.

### **DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency improperly denied Appellant’s request for more CLS hours.

[REDACTED]  
Docket No. 2014-9673 EDW  
Decision and Order

**IT IS THEREFORE ORDERED** that:

The Waiver Agency's decision is **REVERSED** and it must initiate a reassessment of Appellant's services.

*Steven Kibit*

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

SK/db

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

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.