STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-022760 EDW
Case No. [redacted]

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*. upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Attorney [redacted] (P[redacted]) represented Appellant at the hearing. Appellant appeared and testified on Appellant's behalf.

[redacted], Supports Coordinator; appeared and testified on behalf of the Department's MI Choice Waiver Agency, the [redacted] (Waiver Agency).

ISSUE

Whether the Waiver Agency properly determined that payment for movie tickets and other social events tickets for Appellant's care providers was not a Medicaid covered benefit?

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 [redacted] to provide MI Choice Waiver services to eligible beneficiaries.

2. The [redacted] 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 Medicaid beneficiary, who is a quadriplegic.

4. Appellant receives Community Living Supports through the MI Choice

Waiver Program.

5. On [redacted], Appellant inquired whether the MI Choice Program could purchase zoo admission, movie tickets and other items for his direct care worker to accompany him to these events.

6. On [redacted], the Waiver Agency notified Appellant that his request was denied.

7. On [redacted], Appellant was notified in writing of the denial of his request to pay for movie tickets and other social events tickets for his workers.

8. On [redacted], the Michigan Administrative Hearings System received Appellant's request for a hearing to contest the Waiver Agency's determination.

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.H. 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 (Revised January 1, 2016)*

Medicaid Provider Manual, MI Choice Waiver Section 4.1.F. GOODS AND SERVICES (January 1, 2016) states:

Goods and Services are services, equipment or supplies not otherwise provided through either MI Choice or the Medicaid State Plan that address an identified need in the individual plan of services (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements. The item or service would:

- decrease the need for other Medicaid services,
- promote inclusion in the community, and
- increase the participant's safety in the home environment.

These goods and services are only available if the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Goods and Services are only approved by CMS for participants choosing the self-determination option. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the individual plan of services.

Section 6.3 SELF-DETERMINATION states:

Self-Determination provides MI Choice participants the option to direct and control their own waiver services. Not all MI Choice participants choose to participate in self-determination. For those that do, the participant (or chosen representative(s)) has decision-making authority over staff who provide waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring (co-employer)
- Selecting staff from worker registry
- Hiring staff (common law employer)
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the participant's needs and preferences so long as such qualifications are consistent with the qualifications specified in the approved waiver application and the Minimum Operating Standards
- Specifying how services are to be provided and determining staff duties consistent with the service specifications in the approved waiver application and the Minimum Operating Standards
- Determining staff wages and benefits, subject to State limits (if any)
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff (common law employer)
- Discharging staff from providing services (co-employer)
- Reallocating funds among services included in the participant's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Participant budget development for participants in self-direction occurs during the person-centered planning process and is intended to involve individuals the participant chooses. Planning for the participant's plan of service precedes the development of the participant's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. A participant's budget is not authorized until both the participant and the waiver agency have agreed to the amount and its use. In the event that the participant is not satisfied with the authorized budget, he/she may reconvene the person-centered planning process. The waiver services of Fiscal Intermediary and Goods and Services are available specifically to self-determination participants to enhance their abilities to more fully exercise control over their services.

The participant may, at any time, modify or terminate the arrangements that support self-determination. The most effective method for making changes is the person-centered planning process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may be interfering with the success of a self-determination arrangement. The decision of a participant to terminate participation in self-determination does not alter the services and supports identified in the participant's plan of service. When the participant terminates self-determination, the waiver agency has an obligation to assume responsibility for assuring the provision of those services through its network of contracted provider agencies.

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.

MI Choice Medicaid Waiver Program contract, Attachment K, page 48, Section E states:

> 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 funding sources, including third party supports in the community that are available to the participant and paid for by other funding sources. MI Choice funding is the payment source of last resort.

Appellant bears the burden of proving, by a preponderance of evidence, that payment of social events fees for his caregiver/provider are medically necessary.

Appellant testified on the record that he is a quadriplegic. He can be involved in no community activities without a services aide. It is not fair to make his service aids pay for their own admission to movies, the zoo or other events which require admission, when he has funds available in his self-determination budget.

While community life and inclusion are important aspects impacting the quality of life for participants in the MI Choice program that are addressed as part of the Person Centered Planning process, the specific items that Appellant requested are not covered under the program. Supports coordinators seek creative solutions using the participants own resources, community resources, formal and informal supports to meet the desires stated in the person centered plan.

The [redacted] considered goods and services as a possible option for the requested items. While purchasing fares and tickets for events so that Appellant's caregivers may participate in the events may promote inclusion in the community, the provision of payment of admission fees or other items for the use or enjoyment of the the non-participant direct care worker is not a good or services covered by Medicaid. The direct care worker may pay their own way to these events, or Appellant can choose to pay for his caregiver's admission or items during a community outing. The Appellant may request that the establishment waive the fee for disabled participants. CLS includes assisting, reminding, observing and/or training in household activities, Activities of Daily Living or other activities, but does not include payment for activity entry.

Appellant is free to determine the utility of his available resources in whatever fashion he chooses, including payment of his caregivers event entrance fees. However, payment of event entrance fees is not a Medicaid covered service. Medicaid does not reimburse individual for services not covered in policy, nor for services that are not approved in the Appellant's Plan of Service. The Waiver Agency provided sufficient evidence that it implemented the MI Choice procedure in accordance with Department policy; therefore, its actions were 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 denied Appellant's request for payment for social events fees for his direct care workers.

IT IS THEREFORE ORDERED that:

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

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

LYL/[redacted]

[redacted]
Docket No. 15-022760 EDW
Hearing Decision & Order

cc: [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.