RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 16-002477
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Janice Spodarek

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted]. Petitioner appeared and testified. [redacted], caregiver, appeared on behalf of the Petitioner.

[redacted], Assistance Director of MI Health Link and New Business Strategies, represented the Michigan Department of Health and Human Services' (MDHHS) subcontractor, the [redacted] (Respondent, Waiver Agency or [redacted]). [redacted], RN Supports Coordinator, appeared as a witness on behalf of the Department's subcontractor.

ISSUE

Did the Waiver Agency properly deny Petitioner's request for an increase in additional hours?

FINDINGS OF FACT

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

1. Respondent is a contract agent of the MDHHS and is responsible for waiver eligibility determinations and the provision of MI Choice waiver services in its service area.

2. Petitioner is a Medicaid beneficiary who has been diagnosed with congestive heart failure, coronary heart disease, Stoke/CVA, Hemiplegia, and diabetes. (Exhibit A).

3. On approximately [redacted], Petitioner returned to her home after being hospitalized. Petitioner was approved 33.5 hours of CLS under the self-determination program. (Testimony; Exhibit A).

4. On [redacted], Petitioner requested an increase in hours to 45 CLS hours per the Department's evidence. (Exhibit A). At the administrative hearing, Petitioner indicated that she was requesting 6 hours increase. (Testimony).

5. The Respondent's RN's notes regarding the request indicates that the Respondent did not see a justification to increase the hours based on the fact that Petitioner had not had any additional seizures since returning from the hospital. (Exhibit A).

6. On [redacted], the Waiver Agency sent Petitioner written notice that her request for an additional hour of CLS per week was being denied on the basis that medical necessity was not shown. (Exhibit A).

7. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Petitioner in this matter.

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.

Petitioner 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 [redacted] 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 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)*

Here, Petitioner has been receiving CLS through the Waiver Agency and, with respect to such services, 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, April 1, 2014 version
MI Choice Waiver Chapter, pages 12-13

> 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)*

The Medicaid Provider Manual addresses self-determination for the MI Choice Waiver Program:

> **6.3 SELF-DETERMINATION**
>
> 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.

A waiver agency may terminate self-determination for a participant when problems arise due to the participant's inability to effectively direct services and supports. Prior to terminating a self-determination agreement (unless it is not feasible), the waiver agency informs the participant in writing of the issues that have led to the decision to terminate the arrangement. The waiver agency will continue efforts to resolve the issues that led to the termination.

Medicaid Provider Manual,
MI Choice Waiver Chapter,
October 1, 2015, pp. 28-29

However, while CLS are Medicaid covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the MI Choice Waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Here, it is undisputed that the Petitioner has a need for CLS hours. Rather, Petitioner requests an increase.

Petitioner bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in denying her request. Moreover, this Administrative Law Judge is limited to reviewing the Waiver Agency's decision in light of the information it had at the time it made that decision. Given the information available at the time of the denial in this case, Petitioner failed to meet her burden of proof and the Waiver Agency's decision must be affirmed for the reasons set forth below.

First, Petitioner argues that Petitioner has suffered seizures since the denial. However, under general rules of evidence, the jurisdiction of this forum is to review the denial based on the evidence in existence at the time of the denial. Here, the evidence as of the [redacted] denial date did not show that Petitioner had suffered any seizures since returning home.

To the extent Appellant's circumstances have changed or her medical conditions have worsened, she can always re-request that her services be increased. With respect to the decision at issue in this case, however, the denial must be affirmed given the information available at the time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly denied Petitioner's request for additional services based on the available information, and

IT IS THEREFORE ORDERED that

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

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact [redacted]

DHHS -Dept Contact [redacted]

Petitioner [redacted]

Community Health Rep [redacted]

Authorized Hearing Rep. [redacted]