[redacted]
MI [redacted]

Date Mailed: September 19, 2022
MOAHR Docket No.: 22-003432
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

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

After due notice, a telephone hearing was held on September 14, 2022. Daniel Wojciak, Attorney, appeared on behalf of Petitioner. Kimberly Cope, Chief Compliance Officer, appeared on behalf of Respondent, Area Agency on Aging 1B (Department).

Witnesses:

Petitioner	[redacted]
Respondent	Nicole Toole, R.N., Supports Coordinator Susan Miller, LMSW, Clinical Operations Director

Exhibits:

Petitioner	1. 9/8/22 Primary Care Physician Letter 2. Hearing Summary 3. 4/13/22 Notice of Internal Appeal Decision 4. MI Choice Attachment C 5. Authorization Service Discernment Guide 6. 3/1/22 Primary Care Physician Letter
Respondent	A. Hearing Summary

ISSUE

Did the Department properly deny Petitioner's request for additional Community Living Supports (CLS)?

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary who receives benefits from the Department. (Exhibit A, p 16; Testimony.)

2. On February 25th, 2019, Petitioner was involved in a motor vehicle accident resulting in a traumatic brain injury (TBI), fractured skull, broken ankle, broken knees, crushed pelvis and broken neck. (Exhibit A, p 16; Testimony.)

3. On February 18, 2022, Petitioner and [redacted][1], participated in a reassessment. During the assessment, [redacted] was asked if he felt the information provided was accurate and if all the needs were expressed during the 5.25 hour assessment. [redacted] did not mention any other service CLS service needs. (Exhibit A, pp 10, 13-15, 33-42.)

4. Prior to March 7, 2015, Petitioner was approved for 51.5 CLS hours per week. (Testimony.)

5. On March 7, 2022, Petitioner was approved for an additional 9 hours of CLS per week. (Exhibit A, p 1.)

6. On March 9, 2022, the Department issued Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's request for an additional 40 hours of CLS per week was denied. The notice stated specifically:

> [Petitioner] was provided an increase of 9 hours per week for additional toileting assistance, meal preparation, medication reminders, and providing snacks at night in case of low blood sugar. Based on the most recent assessment dated 2/18/2022 [Petitioner's] care needs have not changed except for the care needs outlined above. 60.25 hours of Community Living Supports (CLS) services was determined to be medically necessary for [Petitioner].[2]

7. On March 15, 2022, Petitioner filed an internal appeal seeking 40 additional CLS hours a week. (Exhibit A, p 9.)

8. On April 1, 2022, the Department contacted Petitioner by telephone. During the telephone call, Petitioner indicated he did not request 40 hours of additional CLS care, but rather was requesting 20 hours and further

[1] Petitioner's Ombudsman.
[2] Exhibit A, p 4.

agreed that after the allocation of 9 hours, the request was now at only 11 hours of additional CLS. During the conversation, Petitioner was asked what he needed additional CLS hours for. Petitioner did not articulate any specific needs that were not already addressed in the approved allocation of 60.25. (Exhibit A, p 10.)

9. On April 13, 2022, the Department issued Petitioner a Notice of Internal Appeal Decision – Denial. The notice indicated Petitioner's request for 40 hours of CLS per week was denied. The notice stated specifically:

> [Petitioner] was provided an increase of 9 hours per week for additional toileting assistance, meal preparation, medication reminders, and providing snacks at night in case of low blood sugar. Based on the most recent assessment dated 2/18/2022 [Petitioner's] care needs have not changed except for the care needs outlined above. 60.25 hours of Community Living Supports (CLS) services was determined to be medically necessary for [Petitioner].[3]

10. On August 8, 2022, the Michigan Office Administrative Hearings and Rules (MOAHR) received the Request for Hearing filed in this matter. (Hearing File.)

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. 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 receiving 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 to the Michigan Department of Health and Human Services. Regional agencies, in this case Respondent, 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

[3] Exhibit A, p 9.

> 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.[4]

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.[5]

Types of services that may be offered through the waiver program include:

> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> (1) Case management services.
>
> (2) Homemaker services.
>
> (3) Home health aide services.
>
> (4) Personal care services.
>
> (5) Adult day health services
>
> (6) Habilitation services.
>
> (7) Respite care services.
>
> (8) 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.
>
> (9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.[6]

The Medicaid Provider Manual (MPM) outlines the governing policy for the MI Choice Waiver program and, with respect to services in general, and CLS in particular, the applicable version of the MPM states in part:

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[4] 42 CFR 430.25(b).
[5] 42 CFR 430.25(c)(2).
[6] 42 CFR 440.180(b).

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 person-centered service plan; and
- provided in accordance with the provisions of the approved waiver.

Services must not be provided unless they are defined in the person-centered service plan and must not precede the establishment of a person-centered service plan. 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 within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

MDHHS and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing 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 in the waiver agency's provider network, thereby ensuring freedom of choice.

Where applicable, the participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

* * *

4.1.H. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in community settings. CLS includes assistance to enable participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an ongoing basis when participating in self-determination options. Tasks related to ensuring safe access and egress to the residence are authorized only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision. When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant.

CLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in household activities, Activities of Daily Living (ADL), or routine household care and maintenance.

- Reminding, cueing, observing or monitoring of medication administration.

- Assistance, support or guidance with such activities as:

- Non-medical care (not requiring nurse or physician intervention) – assistance with eating, bathing, dressing, personal hygiene, and ADL;

- Meal preparation, but does not include the cost of the meals themselves;

- Money management;

- Shopping for food and other necessities of daily living;
- Social participation, relationship maintenance, and building community connections to reduce personal isolation;
- Training and assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work;
- Transportation from the participant's residence to medical appointments, community activities, among community activities, and from the community activities back to the participant's residence; and
- Routine household cleaning and maintenance.

- Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered service plan.
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
- Observing and reporting any change in the participant's condition and the home environment to the support coordinator.[7]

Here, as discussed above, Department denied Petitioner's request for additional hours of CLS.

In appealing the decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

[7] MPM, MI Choice Waiver, April 1, 2022, pp 10-13.

Given the available information and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and the Department's decision must therefore be affirmed.

Petitioner, on examination, did not provide any additional areas of need that were not currently being covered by his current plan of service. The testimony corroborates the statements provided in prior discussions between Petitioner and the Department. Although Petitioner provided two doctors notes indicating a need for additional care, the notes do not reflect what knowledge or expertise the writer has regarding the Medicaid program or more specially the waiver program the Petitioner receives his benefits through. Additionally, the notes do not reflect whether or not the writer is aware of the current benefits being received by Petitioner or whether the writer knows how or why those benefits are being allocated.

To the extent Petitioner has additional or updated information to provide regarding his need for additional services, he can always request more services again in the future. With respect to the denial at issue in this case, however, Respondent's decision is affirmed given the information available at the time and the applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Department properly denied Petitioner's request for additional services.

IT IS THEREFORE ORDERED that:

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

CA/dh

Corey Arendt
Administrative Law Judge

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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

Via Electronic Mail:

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