STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-45017 EDW

[redacted],

Appellant

[redacted]/

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] and continued until [redacted]. [redacted], attorney, represented the Appellant. His witness was [redacted]. [redacted], social worker, represented the Department's waiver agency. Her witness was [redacted], Medicaid Program supervisor.

ISSUE

Did the Department properly reduce the Appellant's Community Support Services under the MI Choice Waiver program?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is an [redacted], Medicaid beneficiary.

2. She is afflicted with RA, HTN, osteoporosis, dementia, depression, blood clots and failed hip surgery [displaced fracture of the left femur] with seroma. (See Testimony of [redacted])

3. The Appellant's MI Choice waiver services include assistance with personal care, bathing, dressing, transferring, meal preparation, homemaking, laundry, errands, continence check/help, undressing – with a proposed breakdown into (3) three blocks; morning, afternoon, evening for a total of (6) hours versus the existing (12) hours of service. (Department's Exhibit A, p. 2)

4. The reduction in service was proposed because "… it was determined that her current level of services does not reflect accurately her level of need." (*See* Testimony and Department's Exhibit A, p. 2)

5. The Appellant has been receiving [redacted] of waiver services for the last [redacted]. On quarterly review [8 prior reviews] the service assessment based on LOC has remained extant at 12-hours a day. (See Testimony of [redacted] and Appellant's Exhibit 2, p. 6)

6. The Appellant has primary informal support in her [redacted] spouse. He "verbalized" to the waiver agency that he was is "good health." Although he also reported that he "didn't do much" for his wife beyond checking on her during the night and driving her as needed. He is afflicted with the residuals of prostrate CA, and a recent leg fracture secured with metal plate and screws. He utilizes a foley catheter and collection bag. He uses a powered cart to shop. He uses a cane or walker to ambulate. He is unsteady on his feet. (See Testimony of [redacted] and Department's Exhibit A, p. 8)

7. The Waiver agency also reported informal support from daughter [redacted] who "comes by daily" and sets up medications for the Appellant. The testimony of [redacted] contradicted this. He said that his sister comes over once a week (maybe twice) on her lunch hour to set up the medications for a week. She is not there daily. (See Testimony of [redacted] and Department's Exhibit A, p. 8 and Appellant's Exhibit 2, p. 25)

8. On the [redacted], reassessment the Waiver agency also determined that the Appellant's residence now had limited access resulting in "difficult maneuvering within rooms and without railings – although needed." Previous assessments failed to make this observation. (Department's Exhibit A, p. 9)

9. On [redacted], the Appellant was reassessed and based on a "quality review audit" was determined to need 42-hours of support services. (Department Exhibit A, p. 2)

10. The Department witness reported that the previous assessments were in error. (See Testimony of [redacted])

11. The Appellant was advised of the Department action on [redacted]. (Department's Exhibit A, p. 1)

12. The effective date of action was proposed as [redacted]. (Department's Exhibit A, p. 1)

13. The instant appeal was received by SOAHR on [redacted] (Appellant's Exhibit #1)

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.

The 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 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.
>
> 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)[1] 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)

It is undisputed that the Appellant has a need for personal care services.

The MI Choice waiver defines Service and Personal Care as follows:

> "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 person) or cueing to prompt the participant to perform a task. Personal care services may be 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. Personal care under the waiver differs in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care services in the State plan. The differences between the waiver coverage and the State plan are that the provider qualification and the training requirements are more stringent for personal care as provided under the waiver than the requirements for these services under the State plan. Personal care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the

[1] Services for the chronically mentally ill.

> plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming which are incidental to the service furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care may be furnished outside the participant's home. The participant oversees and supervises individual providers on an ongoing basis when participating in SD options." (Emphasis supplied)
>
> MI Choice Waiver, April 9, 2009; Page 45

> Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services.
>
> *See* 42 CFR 440.230.

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The Appellant is receiving personal care services through the MI Choice waiver. She has assistance with personal care, bathing, dressing, undressing, transferring, meal preparation, homemaking, laundry, errands, continence check/help. Personal care services were reduced from 84 hours to 42 hours a week and spread throughout the day in (3) three blocks consisting of morning, noon, and evening segments wherein the Appellant will receive her reduced ADL/IADL chores in blocks of 1.5 to 2.5 hours of service - or 6 hours a day. Increased reliance on the Appellant's informal supports was noted in the reassessment conducted on [redacted].

While it is clear the Appellant's categories of needs have been addressed by the agency, the proposed reduction in hours is unsupported by the Department's own evidence. There are errors in the written assessment – aside from the over-reliance on the Appellant's primary informal support.

The ALJ finds that the reassessment has understated the Appellant's service needs.

The testimony and evidence of the Department witnesses [redacted] described a reassessment wherein the aide was described as "watching television and playing games" with the Appellant – while the informal supports of the Appellant's daughter and spouse apparently stood ready to transfer the Appellant and provide hands-on services. However, the testimony proved that the daughter was not available and the father was not able to provide these services.

The Appellant's witness, [redacted] testified that the reduction in services was actually decided before the reassessment was conducted. The accuracy of this allegation was captured in a business record from [redacted], [redacted], Scheduling coordinator], memorializing "down the road" reductions for the Appellant – almost a month before the on-site reassessment. See Appellant's Exhibit 2, page 54

The parties and their witnesses agreed that the Appellant's spouse, an informal support, would neither be capable of transferring the Appellant, nor was he capable of providing the bulk of the Appellant's personal care services.

The Appellant's failed hip syndrome militated in favor of significant familiarity and increased frequency with careful repositioning of the Appellant as the medical evidence submitted by the Appellant persuaded this reviewer that sitting in the same position with her exisiting level of joint damage would be contraindicated – particularly given the likelihood of skin breakdown. See Appellant's Exhibit 1, 2, 3.

Obviously a reduction of service hours [by half] would result in a significant extension to the Appellant's time in one seated positon – with only her spouse in attendance. The need for repositioning and complete assistance was acknowledged by [redacted] on cross examination.

The Department argued simply that an error was made on the previous assessments and that the exisiting level of service was not medically necessary – however they provided no medical evidence to support this conclusion. Indeed – the Appellant – by the Department's own testimony and assessment tool is not in an improved condition – nor is her primary informal support.

The Department acknowledged in its assessment document that the Appellant remained incontinent 24/7 as of the [redacted] review – yet had no problem reducing the number of hours the Appellant would be constructively forced to sit in her soiled underclothing awaiting the next able and available service provider.

With the corresponding reduction in services[2] the ability of the informal support to perform these tasks was not supported by the evidence. However, the proofs established that he would be able to observe and report in an emergency.

I found the testimony of [redacted] to be credible when he explained the medical issues behind the Appellant's continued need for waiver services at present levels and for his explanation on the frequency of informal supports [his sister] and the reality of his father's ability.

I found the Department's argument that other assessments were "irrelevant" to be sophistry. Obviously, the new assessment must deal with circumstances as presented – but to ignore history in the face of zero improvement of the Appellant's condition or circumstance begs common sense.

[redacted] of personal care were determined by the Agency as not medically necessary – because the Waiver agency erred in its earlier assessment. However, the Appellant has been assessed 8 times previously and the service level was never reduced. The medical evidence in this record supports the Appellant's argument for reinstatement of previously authorized hours. The errors discovered in the Department's proofs only support reinstatement of preexisting service hours – not their elimination.

I. HAS THE [redacted] APPELLANT IMPROVED?

The issue of Appellant's cognitive status was reviewed at hearing. The Appellant has dementia and depression. In addition to pain levels of 8 out of 10 she is in a position of significant need and a corresponding lessened ability to express herself at a time in her life when pain and soiled undergarments play a major aggravating role.

There was no evidence that the Appellant's circumstance at home by way of informal support or happenstance has improved. There was no medical evidence that the Appellant's physical or mental condition has improved to the point where services could be cut in half. In fact, the medical evidence submitted by the Appellant supported maintenance of existing levels of waiver support. See Appellant's Exhibits 1- 3.

II. IS THE INFORMAL SUPPORT ABLE TO HELP?

The testimony of the parties established that the Appellant's primary informal support is unable to assist with any weight bearing, hands-on transferring of the Appellant or the provision of chores that would stress his physical frailties. As for the [informal support] daughter – the credible testimony of [redacted] persuaded this reviewer that she did not visit daily – but rather once or twice a week – during her lunch hour to assist with medication management – a valuable service to be sure but not one accounting for such a drastic reduction in waiver services.

This ALJ finds the MI Choice agency did offer and authorize appropriate services available under the program to meet the medically necessary needs of the Appellant prior to [redacted]. However, the proposed reduction in the number of hours on reassessment was not supported by the evidence and relied, too heavily, on the unsupported assertion that the Department had simply erred in its prior assessments.

On further review of the exhibits and the testimony in this matter the ALJ makes the following finding:

- Based on the evidence and the testimony at hearing, the Appellant's primary informal support is physically able and mentally competent to operate an emergency communication device – during an emergency.

While this ALJ has concern for the needs of the Alliance to review their programs for quality performance, the MI Choice program requires the agency to provide adequate services where medically necessary.

Based on a review of the policy and evidence, I find that the Department's previous authorization of 84-hours a week of Community Support Services remain medically necessary for the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/28/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.