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) 334-9505

IN THE MATTER OF:

Docket No. 2011-51302 EDW
Case No. 93901335

[redacted],

Appellant
____________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ), pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq*., upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's daughter-in-law, appeared and testified on Appellant's behalf. Appellant also testified on her own behalf through her representative, who translated for her. [redacted], Home Care Manager, represented the Department of Community Health's Waiver Agency, the [redacted] Center, Inc. ("Waiver Agency" or "MORC"). [redacted], Registered Nurse/Supports Coordinator, also testified as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency properly reduce Appellant's services 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 an [redacted] year-old woman and has been diagnosed with hypertension, peripheral vascular disease, arthritis, Parkinson 's disease, anxiety, and depression. (Exhibit 1, pages 7, 15-16).

2. Appellant is enrolled in and has been receiving MI Choice waiver services through MORC. (Testimony of [redacted]; Testimony of [redacted]).

3. MORC 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.

4. On [redacted], MORC staff completed a reassessment of Appellant's services and determined that Appellant no longer required the temporary increase in personal care and homemaking services she had been authorized in [redacted] or [redacted] of [redacted] because the broken bone she suffered in [redacted] of [redacted] had healed. (Testimony of [redacted]).

5. On [redacted], MORC sent Appellant a notice that it was reducing her services by removing the temporary increase in personal care and homemaking. The effective date of the reduction was identified as [redacted]. (Exhibit 1, page 5).

6. On [redacted], the Department received Appellant's request for an administrative hearing. (Exhibit 2, page 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. 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 MORC, 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 440.180(b))

Moreover, the Michigan Department of Community Health, Medical Services Administration issued bulletin number MSA 11-27 on July 1, 2011, effective August 1, 2011, for the purpose of adding a MI Choice Policy Chapter to the Medicaid Provider Manual. This new policy chapter provides in part:

4.1.B. HOMEMAKER

Homemaker services include the performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker when the individual regularly responsible for these activities, i.e., the participant or an informal supports provider, is temporarily absent or unable to manage the home and upkeep for himself or herself. Each provider of Homemaker services must observe and

report any change in the participant's condition or of the home environment to the supports coordinator.

4.1.C. PERSONAL CARE

Personal Care services encompass 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.

Services provided through the waiver differ in scope, nature, supervision arrangement, or provider type (including provider training and qualifications) from Personal Care services in the State Plan. The chief differences between waiver coverage and State Plan services are those services that relate to provider qualifications and training requirements, which are more stringent for personal care provided under the waiver than those provided under the State Plan.

Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. These services may also include assistance with more complex life activities. The service may include the preparation of meals but does not include the cost of the meals themselves. When specified in the plan of service, services may also include such housekeeping chores as bed making, dusting, and vacuuming that are incidental to the service furnished or that are essential to the health and welfare of the participant rather than the participant's family. Personal Care may be furnished outside the participant's home.

(MSA 11-27, pages 10-11)

Here, it is undisputed that the Appellant has a need for some services and she has been receiving both personal care and homemaking services. However, Medicaid beneficiaries are 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 C.F.R. § 440.230.

In this case, RN testified that, after suffering a fall in , Appellant was allocated an additional hour of services each week. After the increase, Appellant received 4 hours of services per week. (Testimony of). RN also testified that the additional hour of services was meant to be temporary and should have been

terminated once Appellant's bone healed. (Testimony of). According to RN , broken bones usually take four to six weeks to heal, but Appellant has been authorized for increased services for approximately a year and it appears that previous workers erred by continuing to authorize 4 hours of services per week. (Testimony of). RN further testified that, following a routine reassessment in , she felt Appellant's bone had healed and that Appellant had returned to the level Appellant was at before she broke her shoulder bone. (Testimony of). Accordingly, RN determined that Appellant no longer required a higher level of care and that Appellant's services should be reduced. (Testimony of).

However, while RN generally testified as to why she felt Appellant no longer required the additional hour of services, her testimony is not supported by the evidence submitted by the Waiver Agency, *i.e.* the reassessment report dated . (Exhibit 1, pages 7-27). That report does not provide that Appellant's condition had improved or that any bones had healed. (Exhibit 1, pages 7-27). Instead, it repeatedly notes that Appellant has not undergone any acute changes in functioning, functional status or function health since her last assessment, which took place in and which resulted in Appellant being allocated 4 hours of services per week. (Exhibit 1, pages 15, 24, 26). Moreover, the reassessment report provides that Appellant requires significant assistance. According to RN ' report, Appellant is totally dependent on others for meal preparation, ordinary housework, managing medications and shopping while also requiring extensive assistance with using stairs, transportation, bed mobility, transferring, dressing and bathing. (Exhibit 1, pages 22-24).

RN did note in the reassessment report that Appellant was receiving an increase in services due to a fall the year before and that she would do a LOC to reevaluate if the increase should be continued. (Exhibit 1, page 15). She also noted that near the end of the report that a separate LOC was to be done with respect to the temporary increase. (Exhibit 1, page 26). Nevertheless, no LOC was provided as part of the record and there is no documentation supporting RN ' general testimony.

Additionally, the reassessment report is consistent with Appellant's representative's testimony regarding the care Appellant requires due to the lingering effects on the broken bone on Appellant's functioning. (Testimony of). Appellant's representative also noted that Appellant still requires massage therapy and physical therapy due to the broken bone. (Testimony of). Similarly, RN testified that Appellant's shoulder might not be 100%, even after a year, and the reassessment report acknowledges that Appellant is still undergoing physical therapy. (Testimony of ; Exhibit 1, pages 24-25).

Given Appellant's representative's testimony and the reassessment report itself, this Administrative Law Judge finds that Appellant has met her burden of demonstrating by a preponderance of the evidence that the Waiver Agency erred. The Waiver Agency based its reduction solely on the fact that Appellant's broken bone had healed and it failed to assess whether Appellant medically required 4 hours a week of services. Based on evidence in the record, Appellant does require all of that time and the

reduction should not have been made.[1]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency improperly reduced Appellant's services through the MI Choice Waiver Program.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 11/2/2011

***** 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.

[1] This Administrative Law Judge would also note that the Waiver Agency failed to provide proper notice in this case. While Appellant's services were reduced one day after the Adequate Action Notice was sent out (Exhibit 1, page 5), the Code of Federal Regulations provides that , with the exception of certain circumstances not relevant here, the Waiver Agency must mail a notice at least 10 days before the date of action. *See* 42 C.F.R. § 431.211. The Waiver Agency's representative asserted that it did not have to provide additional notice in this case because the hour of services being taken away was only a temporary authorization. However, it is undisputed that there was no specific end date on the authorization of services and that Appellant's services were reduced without adequate notice.