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) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 14-010115 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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared but did not testify. Appellant was represented by [redacted], grand-daughter and caregiver.

[redacted], Manager of [redacted], appeared and testified on behalf of the Department's MI Choice Waiver Agency, the [redacted] ([redacted] or Waiver Agency). [redacted], Social Worker Supports Coordinator, and [redacted], Supports Coordinator, appeared as a witness for the Waiver Agency. Neither witness had personal knowledge of the case.

ISSUE

Did the Waiver Agency properly reduce Appellant's Community Living Supports (CLS) from 35 hours per week to 25 hours per week?

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 [redacted] to provide MI Choice Waiver services to eligible beneficiaries. (Exhibit A, Testimony)

2. [redacted] must implement the MI Choice Waiver program in accordance with Michigan's waiver agreement, Department policy and its contract with the Department. (Testimony)

3. Appellant is a [redacted] year-old Medicaid beneficiary. Appellant is diagnosed with hypertension, OA, dementia, Parkinson's, liver cirrhosis, dysphagia, GERD. (Exhibit A,8; Testimony)

4. On [redacted], the Agency did an in-home reassessment for re-enrollment pursuant to a post discharge from in-patient rehabilitation. The Primary Support Coordinator (PSC) used the [redacted] standardized Plan of Care Worksheet to calculate a base minimum for CLS hours. (Exhibit A.3) The Worksheet calculated 18.58 hours per week. (Exhibit A.1) The Agency testimony at the administrative hearing and the statement on the Agency's Hearing Summary was that the Agency was that the PSC added an additional 7 hours weekly to the chart. (Exhibit A.3; Testimony)

5. Appellant's previous hours for the EDW CLS program were 35 hours per week.

6. Appellant's representative testified that the PSC stated to her that she made no changes and that she "did not understand why the computer decreased the hours other than that the agency is cutting back hours." (Testimony)

7. The PSC who conducted the in-home re-assessment was not available at the administrative hearing for testimony and/or cross-examination. The PSC has since left the Agency; the Agency did not request a subpoena.

8. On [redacted] the Agency issued an Advance Action Notice indicating that Appellant's CLS hours will be reduced. The specific number of hours, and, the reason for the reduction and/or the allocation for CLS services is not explained on the negative action. (Exhibit A, pp 3-4; Testimony)

9. On [redacted] the DCH issued a letter to the Agency's Chief Executive Officer-Tina Abbate Narzolf mandating that the Agency immediately cease using its Care Plan Worksheet policy and the Care Plan Worksheet itself due to the worksheet being in noncompliance with DCH policy. In addition, DCH mandated that the Agency immediately stopping the use of the worksheet, and instructed the Agency to pull all cases that have had a decrease in hours based on the use of the worksheet and conduct a re-evaluation of all persons. The Agency stipulated at the administrative hearing that the worksheet used in the present case is the same worksheet referenced by the DCH letter of [redacted]. (Testimony)

10. The Agency testified that the case herein is one of the cases that would fall under the mandates of the DCH [redacted] letter, but argued that it disagrees with the mandate testifying that "…we don't believe that we have used the wrong tool. We use the tool as a base line and provided other hours …" (Testimony, [redacted])

11. On [redacted], the Michigan Administrative Hearing System received a request for hearing from Appellant. (Exhibit 1). The Agency testified that it reinstated the negative action pending the outcome of the administrative hearing.

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.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.
>
> *Medicaid Provider Manual*
> *MI Choice Waiver Section*
> *July 1, 2014, pp 12-13*

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. However, many of the community options for supports that are also funded with Medicaid monies may also be considered payers of last resort.

Appellant bears the burden of proving eligibility, by a preponderance of evidence. If Appellant rebuts the Agency's evidence, then the burden shifts to the Agency.

The action herein was the reduction from 35 CLS hours per week to 25. The Waiver Agency witness testified that Appellant's CLS hours were reduced based on a reassessment conducted on [redacted] in which the Supports Coordinator determined that the worksheet chart calculated 18 hours, and, the Supports Coordinator added 7 hours. The Agency further argued that assessment(s) are person centered, and that they do not only use the worksheet tool and that the Worksheet is not strictly applied

Appellant disagreed-Appellant argued that the Supports Coordinator stated that based

on her assessment, nothing had changed, but that the computer calculated fewer hours per week than Appellant was previously receiving. Appellant indicated that the Coordinator represented to her that she believed that perhaps it was because the Agency was cutting back hours.

Here, the Supports Coordinator who conducted the review was not present at the administrative hearing. The Support Coordinator evidentially, has since left the Agency. The Agency did not request a subpoena. None of the individuals at the administrative hearing had personal knowledge of this case. The individual who did have personal knowledge was not present for testimony and/or cross-examination. Appellant raised sufficient questions as to the action taken, and, represented that that the Supports Coordinator also raised questions regarding the tool.

Moreover, a review of the evidence herein does not contain sufficient explanation or evidence to show how Appellant's [redacted] evaluation of her CLS needs have decreased from the prior level of 35 hours. The lack of documentation showing the prior level adds credibility to purported statements of the Supports Coordinator.

In addition, the DCH letter of [redacted] finding that the Agency Worksheet is not in compliance with policy rebuts the presumption that the Agency's actions comply with Michigan DCH policy and procedure. This ALJ is in no position to evaluate the Agency's disagreement with its contractor. The purview of an administrative law judge is to review the Agency's actions, and, to make a determination if that action is correct under DCH policy and procedure, and not contrary to law. The DCH [redacted] letter plainly states that the subcontracting agency's policy and worksheet tool is not in compliance with DCH policy.

As the Agency testified that the case herein used a worksheet deemed out of compliance with the Michigan Department of Community Health's policy and law pursuant to the [redacted] DCH letter to the Agency, the agency's actions cannot be upheld.

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 did not properly propose to reduce Appellant's CLS hours from 35 hours per week to 25 hours per week.

IT IS THEREFORE ORDERED that:

The Agency's proposed decision is REVERSED.

The Agency is ordered to reinstate Appellant's CLS hours to 35 per week, if not previously done. The Agency is further ordered to reassess Appellant's EDW case in accordance with the mandates of the DCH [redacted] letter to the Agency regarding the Plan of Care Worksheet and Policy.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Acting Director
Michigan Department of Community Health

cc: [redacted]

JS[redacted]

Date Signed: [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.