

**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:

Docket No. 2014-11375 EDW

██████████

██████████

██████████

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.*, and upon the Appellant's request for a hearing.

After due notice, an in person hearing was held on ██████████ ██████████ ██████████. Appellant's mother, appeared and testified on Appellant's behalf. Appellant; ██████████ ██████████, Appellant's father; ██████████, an advocate; and ██████████, Appellant's nurse; also testified on Appellant's behalf. ██████████, Quality and Training Manager, appeared and testified on behalf of the Department of Community Health's Waiver Agency, ██████████ ("Waiver Agency" or "██████████"). ██████████, registered nurse/supports coordinator, and ██████████, Chief Community Care Officer, also testified as witnesses for the Waiver Agency.

ISSUE

Did the Waiver Agency proper decide to 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 a ██████ year-old Medicaid beneficiary who has been diagnosed with centronuclear myopathy; anxiety; depression; extrinsic asthma, NOS; cataract, NOS; and diverticulitis. (Petitioner's Exhibit 2, page 1; Respondent's Exhibit A, pages 8-9).
2. Appellant's representative/mother has durable power of attorney with respect to Appellant's healthcare, custody, and medical treatment. (Petitioner's Exhibit 2, pages 1-2).

¹ A telephone hearing was originally scheduled for ██████████, but the matter had to be adjourned and rescheduled after Appellant requested an in person hearing.

3. ██████████ 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. Appellant has been receiving services through the Waiver Agency, including private duty nursing (PDN) and Community Living Supports (CLS). (Respondent's Exhibit A, page 16).
5. ██████ days a week, Appellant receives ██████ hours per day of PDN and ██████ hours per day of CLS. (Respondent's Exhibit A, page 16; Testimony of ██████████).
6. The other ██████ days a week, Appellant receives ██████ hours per day of PDN and ██████ hours of CLS. (Respondent's Exhibit A, page 16; Testimony of ██████████).
7. On ██████████ conducted a reassessment in Appellant's home with Appellant and his parents. Appellant's nurse was also present in the room while assisting Appellant. (Respondent's Exhibit A, pages 1-18).
8. During that assessment, it was noted that Appellant's condition had deteriorated in the ██████ days prior to the reassessment. (Respondent's Exhibit A, page 15).
9. Specifically, Appellant had been hospitalized approximately a month before the reassessment due to his diverticulitis and that condition was still hindering his rehabilitation and increasing his stress. (Respondent's Exhibit A, pages 3, 7).
10. Appellant's mother also reported that Appellant is weaker since his last hospitalization. (Respondent's Exhibit A, page 15).
11. Regarding his needs, it was also noted that Appellant continues to require tracheostomy care; ventilator care; suctioning, including tracheostomy suctioning, oral suctioning, and deep suctioning; tube feeding; percutaneous endoscopic gastrostomy (PEG) care; medication management and administration; straight catheterization care; cough assist treatments; percussion vest assistance; and albuterol treatments. (Respondent's Exhibit A, pages 11, 15).
12. It was further noted that Appellant also continues to be totally dependent on others in the areas of bed mobility, dressing, eating, toilet use, bathing, transferring, meal preparation, housework, managing finances, and shopping. (Respondent's Exhibit A, pages 13-15).

13. With respect to Appellant's care, Appellant mother further reported difficulties finding staff to work all of the CLS hours Appellant was approved for and, consequently, Appellant has not been utilizing all of those hours. (Respondent's Exhibit A, page 16).
14. Wejrowski offered to assist her in finding an agency to fill those hours, but Appellant's mother declined because of her doubts about the level of care an agency's aides would provide. (Respondent's Exhibit A, page 16).
15. It was further noted that, while Appellant's father works full-time and both his parents have health issues, they are his primary informal supports and provide the necessary care at time when nurses or aides are not present. (Respondent's Exhibit A, pages 4, 8).
16. Following that reassessment, ██████████ staff reviewed Appellant's services and determined that Appellant's services should be reduced. (Testimony of ██████████; Testimony of ██████████).
17. In making that decision, the Waiver Agency utilized the provisions of the Private Duty Nursing Chapter of the Michigan Medicaid Provider Manual (MPM), including descriptions of various Intensity of Care categories and a "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis". (Testimony of ██████████).
18. Specifically, it determined that, given Appellant's high intensity of care category; the fact that Appellant has ██████ caregivers, one of whom works full-time; and the fact that both of Appellant's caregivers have significant health issues; the maximum amount of PDN that Appellant could be approved for under policy is an average of ██████ hours per day. (Testimony of ██████████).
19. Additionally, the Waiver Agency also noted that, despite the fact that Appellant's father works full-time and that both his parents have health issues, Appellant's parents have consistently been covering the unused CLS hours and providing at least ██████ hours a day of care. (Testimony of ██████████ Testimony of ██████████).
20. Given its determinations regarding the cap on PDN hours and the ability of Appellant's caregivers to provide care ██████ hours a day, the Waiver Agency further determined that the previously authorized amount of services was no longer medically necessary. (Testimony of ██████████ Testimony of ██████████).
21. On ██████████, the Waiver Agency sent Appellant written notice that his services would be reduced on ██████████ ██████████ ██████████. (Respondent's Exhibit C, pages 1-2).

22. Specifically, while Appellant would continue to receive █████ hours of PDN and █████ hours of CLS, █████ days a week, he would now only receive █████ hours of PDN and █████ hours of CLS the other █████ days of the week. (Respondent's Exhibit C, page 1).
23. On ████████████████████ the Michigan Administrative Hearing System (MAHS) received a request for hearing in this matter. (Petitioner's Exhibit 1, pages 1-3).
24. Given the timing of the request for hearing, the reduction was not implemented and will not be implemented while this matter is pending. (Testimony of ██████).

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.

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 Senior Alliance, 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)

In this case, as discussed above, Appellant has been receiving PDN and CLS through [REDACTED] and, with respect to such services, the 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.

* * *

4.1.P. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) services consist of individual and continuous nursing care (in contrast to "Skilled Nursing" services characterized by part-time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to a participant at home. MI Choice participants 18-21 years old who meet the eligibility requirements for Medicaid State Plan PDN services will

continue to receive PDN services through the Medicaid State Plan and will not receive PDN services through MI Choice. Older MI Choice participants may continue to receive PDN services as a MI Choice service.

Participants receiving PDN services must remain on active status when determining reassessment schedules. Refer to the Reassessment of Participants subsection of this chapter for additional information. PDN services cannot be used in place of, or as a substitute for, other waiver or State Plan services.

*MPM, October 1, 2013 version
MI Choice Waiver Chapter, pages 12-13, 15*

However, while both PDN and CLS are 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 Appellant has a medical need for both PDN and CLS, and he has continuously been receiving such services. However, the amount of such services is in dispute. As discussed above, ██████████ notified Appellant that it has decided to reduce the services he was receiving █ days a week from █ hours of PDN and █ hours of CLS per day to █ hours of PDN and █ hours of CLS per day. Appellant would also continue to receive █ hours of PDN and █ hours of CLS the other █ days of the week.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in deciding to reduce his services

According to the Waiver Agency, it decided to reduce Appellant's services on the basis that policy limited Appellant's PDN services to an average of █ hours per day, Appellant's parents could provide care █ hours a day, and CLS workers could provide care at all other times.

With respect to the alleged policy limitation on PDN services, the Waiver Agency relied on sections of the Private Duty Nursing Chapter of the MPM:

2.4 DETERMINING INTENSITY OF CARE AND MAXIMUM AMOUNT OF PDN [CHANGE MADE 4/1/13]

As part of determining the maximum amount of PDN a beneficiary is eligible for, his Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

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- The beneficiary’s medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the number of hours) that can be authorized for a beneficiary is based on several factors, including the beneficiary’s care needs which establish medical necessity for PDN, the beneficiary’s and family’s circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated in the guide.

Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g.,

additional dependent children, additional children with special needs, and required nighttime interventions) that impact the caregiver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning and should be considered when determining the actual number of hours (within the range) to authorize.

FAMILY SITUATION/ RESOURCE CONSIDERATIONS		INTENSITY OF CARE		
		Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	6-12	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day
<p>* Factor III limits the maximum number of hours which can be authorized for a beneficiary:</p> <ul style="list-style-type: none"> ▪ Of any age in a center-based school program for more than 25 hours per week; or ▪ Age six and older for whom there is no medical justification for a homebound school program. <p>In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III, applies.</p>				

*MPM, October 1, 2013 version
MI Choice Waiver Chapter, pages 11-12*

Here, as discussed above, the Waiver Agency found that Appellant has a high intensity of care category; two caregivers, one of whom works full-time; and that both of his caregivers have significant health issues. According to the Waiver Agency, after applying that information to the above Decision Guide, it was determined that the maximum amount of PDN that Appellant could receive was an average of [REDACTED] hours per day.

However, even assuming the Decision Guide applies to this case and the Waiver Agency correctly calculated the maximum number of hours that could be approved, Appellant would be receiving less than the maximum amount identified by the Waiver Agency, *i.e.* an average of [REDACTED] hours per day. If the proposed reduction is upheld, Appellant would be authorized for [REDACTED] hours a day, [REDACTED] days a week, and [REDACTED] hours a day, [REDACTED] days a week, of PDN, with the total amount coming to [REDACTED] hours of PDN each week. An average of [REDACTED] hours a day, however, should come to [REDACTED] hours a week of PDN.

Moreover, even assuming the Decision Guide applies to this case, it is clear that the Waiver Agency incorrectly calculated the maximum number of PDN that could be authorized. As discussed above, the Waiver Agency found that Appellant has a high intensity of care category; ██████ caregivers, one of whom works full-time; and that both of his caregivers have significant health issues. Taking those findings into account, Appellant could have been authorized a maximum of an average of ██████ hours per day. The Waiver Agency appears to have failed to note that it could have added ██████ hours a day as part of Factor II due to the fact that both of Appellant's caregivers have significant health issues and Appellant's Factor I score is less than or equal to ██████ hours.

The Waiver Agency's witnesses acknowledged the errors in applying the Decision Guide during the hearing, but also argued that such errors are irrelevant as Appellant's parents have demonstrated the ability to provide care ██████ hours a day and the Waiver Agency will still be providing services for the remaining ██████ hours each day.

However, that argument conflates the PDN and CLS services Appellant is receiving and ignores the fact that Appellant's PDN was reduced despite the fact that Appellant's medical condition has only deteriorated in the ██████ days prior to the reassessment and his care needs remain the same. The Waiver Agency offered no basis for the reduction in PDN other than that the Decision Guide capped such services and, given the errors made when utilizing that guide, the proposed reduction in services must be reversed.

Additionally, this Administrative Law Judge finds that proposed reduction in services must also be reversed on the basis that the Decision Guide utilized by the Waiver Agency does not apply to PDN through the waiver program.

There is no authority or basis for applying the Decision Guide of the Private Duty Nursing Chapter of the MPM to PDN services through the MI Choice program found in the MPM itself, the Waiver's Agency's contract with the Department, or the Minimum Operating Standards for MI Choice Waiver Program Services maintained and published by the Department.

The specific section of the Private Duty Nursing Chapter of the MPM discussing the Decision Guide expressly states that the "Decision Guide is used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit and defines the 'benefit limitation' for individual beneficiaries", MPM, October 1, 2013 version, MI Choice Waiver Chapter, page 11, and there is no suggestion that it was also meant to determine nursing hours under other programs, such as the MI Choice Program.

Similarly, the specific section of the MI Choice Waiver Chapter of the MPM discussing PDN through the waiver program makes no mention of the Decision Guide of the Private Duty Nursing Chapter and does not refer to any decision guide used to calculate hours. See MPM, October 1, 2013 version, MI Choice Waiver Chapter, page 15. It also reiterates that MI Choice PDN serves and Medicaid State Plan PDN services are separate services applying to different age groups. See MPM, October 1, 2013 version,

MI Choice Waiver Chapter, page 15. Such an age distinction is significant, as the Decision Guide identifies factors that would be more likely to apply for younger beneficiaries, such as being in school and caregivers living in the same home.

In response, the Waiver Agency's witnesses note that MI Choice is a Medicaid program governed by the MPM, including the Private Duty Nursing Chapter, and that they were directed to the Decision Guide by a representative of the Department, who also identified it as a new policy effective ██████████.

However, the mere fact that the MI Choice program is a Medicaid program does not resolve this issue as the various chapters and sections of the MPM have different areas of applicability. Here, there were no relevant changes between the ██████████ and ██████████ versions of the MPM with respect to PDN that would suggest any new policy of applying the Private Duty Nursing Chapter to MI Choice services and, instead, the language of the MPM has continually limited use of the Decision Guide to State Plan PDN services.

Additionally, even if the Waiver Agency was unofficially directed to the Decision Guide by the Department, that direction appears to be in error for the reasons discussed above and, in any event, this Administrative Law Judge is bound by the official, established policy applicable to this case.

Given the applicable policy discussed above, there is no basis for applying the Decision Guide used for State Plan PDN services to the services through the MI Choice Program and the Waiver Agency erred in reducing Appellant's services pursuant to that guide.

Overall, the Waiver Agency based the reduction in services in this case on the basis that policy limited Appellant's PDN services to an average of ██████ hours per day, Appellant's parents could provide care ██████ hours a day, and CLS workers could provide care at all other times. However, as discussed above, the Decision Guide used by the Waiver Agency to calculate the maximum number of PDN numbers does not apply to this case and, even if it did apply, the Waiver Agency miscalculated the maximum number of hours that could be authorized. Moreover, even assuming for the sake of argument that Appellant's parents can provide ██████ hours a care every single day, the error in using the guide is not harmless merely because the Waiver Agency would still be proving a total of ██████ hours of services each day. PDN is not the same as CLS; Appellant is entitled to all medically necessary PDN; and the Waiver Agency cannot simply replace PDN with CLS without reason. No such reason exists in this case, where Appellant's medical condition has only worsened, his needs have not changed, and the only basis offered by the Waiver Agency was the cap on PDN found in the inapplicable Decision Guide.

To the extent that the Waiver Agency believes Appellant is receiving more services than medically necessary, it remains free to reassess him under the proper criteria and, if necessary, notify him in advance of any proposed reduction and his right to appeal any

[REDACTED]
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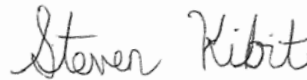
negative action. The decision at issue in this case, however, is reversed for the reasons discussed above.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency improperly decided to reduce Appellant's services.

IT IS THEREFORE ORDERED that:

The Waiver Agency's decision to reduce Appellant's services is
REVERSED.



Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc:

[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.