STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-004080 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*., and upon Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted], an attorney with [redacted] represented Appellant [redacted]. was also present on Appellant's behalf. Appellant and [redacted], one of his care providers, testified as witnesses for Appellant. [redacted], registered nurse/manager, appeared and testified on behalf of the Michigan Department of Health and Human Services' Waiver Agency, the [redacted] ("Waiver Agency" or "[redacted]"). [redacted] registered nurse/supports coordinator, also testified on behalf of the Waiver Agency.

ISSUE

Did the Waiver Agency properly decide to terminate Appellant's services?

FINDINGS OF FACT

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

1. [redacted] is a contract agent of the Michigan Department of Community Health and is responsible for waiver eligibility determinations and the provision of MI Choice waiver services in its service area.

2. Appellant is a [redacted] year-old Medicaid beneficiary who has a medical history that includes two strokes, coronary artery disease, and high blood pressure. (Exhibit A, page 20).

3. Appellant is unable to move his lower extremities and has limited movement in his upper extremities. (Exhibit A, page 20).

4. Due to his medical conditions, Appellant is totally dependent on others for all Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). (Exhibit A, page 20).

5. Appellant had been receiving services through the Waiver Agency, including Community Living Supports ("CLS") 24 hours a day, [redacted] days a week; a Personal Emergency Response System ("PERS") unit; supports coordination; private duty nursing once a week; and transportation (Exhibit A, page 20).

6. On [redacted] gave Appellant a form stating that "[b]ased on the complexity of care requiring extensive [redacted]-hour care/supervision . . . it is the determination of the Project Choice/MI Choice that this individual can best be served in a nursing facility." (Exhibit A, page 27).

7. Appellant checked on the form that he was rejecting [redacted] recommendation. (Exhibit A, page 20).

8. On [redacted] conducted a [redacted] day reassessment in Appellant's home. (Exhibit A, page 31).

9. Appellant had no changes or improvements in his medical conditions or his needs at the time of that visit. (Testimony of [redacted].

10. On [redacted], the Waiver Agency sent Appellant written notice of its decision to reduce Appellant's CLS from [redacted] hours a day, [redacted] days a week, to [redacted] hours a day, [redacted] days a week. (Exhibit A, pages 32-33).

11. The notice also stated that: "The reason for this action is based on on [sic] Assessment done on [redacted]." (Exhibit A, page 32).

12. The reduction was to take effect on [redacted]. (Exhibit A, page 32).

13. On [redacted] Appellant informed [redacted] during a telephone conversation that he never received the written notice. (Testimony of Appellant; Testimony of [redacted]).

14. That same day, the Waiver Agency sent another written notice stating that his CLS would be reduced from [redacted] hours a day, [redacted] days a week, to [redacted] hours a day, [redacted] days a week. (Exhibit A, pages 34-35).

15. The second notice also stated that: "The reason for this action is based on your [redacted] Assessment." (Exhibit A, page 34).

16. The second notice further provided that the reduction was to take effect on [redacted] (Exhibit A, page 34).

17. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-3).

18. Given the appeal, the proposed termination was not implemented and Appellant's services have remained in place while this matter is pending. (Testimony of Appellant; Testimony of [redacted]

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 Health and Human Services. 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. *See* 42 CFR 430.25(c)(2).

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:
>
> - 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)*

Here, Appellant has been receiving CLS through the Waiver Agency and, with respect to such services, the applicable version of the Michigan Medicaid Provider Manual (MPM) states:

> **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 include 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. Transportation to medical appointments is covered by Medicaid through DHS.

CLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in household activities, ADL, or routine household care and maintenance.

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

- Assistance, support and/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/or assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work;

  - Transportation (excluding to and from medical appointments) from the participant's residence to 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 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 supports coordinator.

These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available 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.

CLS services cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere. The distinction must be apparent by unique hours and units in the approved service plan.

MPM, January 1, 2015 version
MI Choice Waiver Chapter, pages 13-14

Here, based on the [redacted] assessment, the Waiver Agency has decided to reduce Appellant's CLS from [redacted] hours a day, [redacted] days a week, to [redacted] hours a day, [redacted] days a week. Appellant has appealed that decision and, in doing so, bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred.

Appellant first argues that the Waiver Agency's decision to reduce his services must be reversed because it failed to provide him with proper notice of that negative action. With respect to notice of negative actions and appeals involving MI Choice, the Michigan Medicaid Provider Manual (MPM) states:

SECTION 11 - APPEALS

The Michigan Department of Community Health has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E of the Code of Federal Regulations. Provider appeal rights conform to the requirements of Michigan law and rules found at MCL 400.1 et seq. and MAC R 400.3401 et seq.

11.1 PARTICIPANT APPEALS

MI Choice has established notice and appeals requirements to which waiver agencies must adhere when adverse action has been taken for program applicants or participants. According to 42 CFR 431.201 "Action" means a termination, suspension, or reduction of Medicaid eligibility or of covered services. This also includes determinations by the waiver agent that the applicant or participant does not meet the nursing facility level of care criteria and other denials of Medicaid eligibility or of covered services.

* * *

11.1.B. ADVANCE ACTION NOTICES

An Advance Action Notice must be sent to MI Choice participants when action is being taken to reduce, suspend, or terminate service(s) a participant currently receives. This notice must be provided at least 12 days in advance of the intended action.

An Advance Action Notice is also issued if it is determined that a reduction in level or number of services is warranted based on the participant's current assessment. The notice must inform the participant that services will not be reduced until a formal decision has been rendered through the Medicaid Fair Hearings process if the participant formally requests a hearing before the specified date of the intended action.

> **11.1.C. NOTICES**
>
> Advance Action Notices and Adequate Action Notices that relate to the LOCD process are posted on the MDCH website. (Refer to the Directory Appendix for website information.)
>
> Waiver agencies may use additional notices for actions not related to the LOCD process. These notices must be approved by MDCH prior to use to assure compliance with 42 CFR 431.210. Waiver agencies must supply a copy of the Request for Hearing form (DCH-0092) and a return envelope with each notice sent to an applicant or participant, or any time an applicant or participant requests such material. Waiver agencies are required to assist applicants or participants who request help in filing an LOCD exception review through the Michigan Peer Review Organization (MPRO), or a formal appeal for any reason through the Medicaid fair hearings process.
>
> *MPM, January 1, 2015 version*
> *MI Choice Waiver Chapter, pages 38-39*

Moreover, the section of the Code of Federal Regulations referenced in the MPM, 42 CFR 431.210, also provides:

> A notice required under § 431.206(c)(2), (c)(3), or (c)(4) of this subpart must contain--
>
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
>
> (b) The reasons for the intended action;
>
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
>
> (d) An explanation of--
>
> > (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

> (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
>
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Given the above policy and regulation, the notice provided in this case was inadequate and the decision to reduce Appellant's services must therefore be reversed. With respect to the reason for the reduction, the notice in this case only stated: "The reason for this action is based on your [redacted] Assessment" and, by just referencing an assessment, the notice failed to provide advance notice of the reason for the intended action as required by 42 CFR 431.210(b), especially where the assessment report was not provided to Appellant and it is undisputed that Appellant's needs and medical conditions have not changed. By failing to provide advance written notice of the reason for that intended action, the Waiver Agency has failed to provide Appellant with proper notice in this case and its decision to reduce Appellant's services must therefore be reversed.

Appellant also argues that, even if the notice was proper, the Waiver Agency stilled erred in making the decision to reduce Appellant's services. In support of that argument, Appellant noted that, while the Waiver Agency stated that the proposed reduction was based on the [redacted] assessment, it was undisputed that there had been no changes or improvements in Appellant's medical conditions or his needs at the time of [redacted] assessment. Moreover, it is also undisputed that Appellant is unable to` move his lower extremities and has limited movement in his upper extremities; he is totally dependent on others for all ADLs and IADLs; and that the Waiver Agency previously recommended that he receive [redacted] hour care/supervision due to the complexity of care that he requires.

Despite its recommendation that Appellant needs [redacted] hour care/supervision and the lack of any changes in his conditions or needs, the Waiver Agency asserts that the reduction is proper because at least some of the care that Appellant receives is supervision and CLS through the Waiver Agency must be hands-on assistance. However, the Waiver Agency failed to cite to any policy supporting its assertion that the assistance must be hands-on and, as quoted above, the MPM generally provides that CLS coverage may include "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."

Accordingly, given the Waiver Agency's failure to support its decision with any policy, in addition to Appellant's undisputed and unchanged need for supports [redacted] hours a day, [redacted] days a week, the undersigned Administrative Law Judge finds that Appellant has met his burden of proving by a preponderance of the evidence that the Waiver Agency erred in deciding to reduce his services and the decision must therefore be reversed.

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 terminate Appellant's services.

IT IS THEREFORE ORDERED that:

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

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

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.