

## **ISSUE**

Did Respondent properly decide to reduce Petitioner's Personal Care 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. Respondent is an Integrated Care Organization (ICO) contracted by the Michigan Department of Health and Human Services (Department or MDHHS) and the Centers for Medicare & Medicare Services (CMS) to provide covered services through the MI Health Link managed care program.
2. Petitioner is enrolled in the MI Health Link program and has been authorized for services through Respondent. (Testimony of Petitioner; Testimony of Respondent's representative).
3. As part of his services, Petitioner was approved for 15.5 hours per week of Personal Care Services. (Exhibit A, page 14).

4. On February 20, 2024, a Care Coordinator completed a reassessment with Petitioner in Petitioner's home. (Exhibit A, pages 6-13).
5. During that reassessment, Petitioner reported, among other things, his worsening health; his continuing need for assistance; and the adaptive equipment he employs. (Testimony of Petitioner).
6. On March 13, 2024, Respondent sent Petitioner written notice that it had decided to reduce his personal care services to 6.25 hours per week. (Exhibit A, pages 19-32).
7. With respect to the reason for that decision, the notice stated:

You have been getting Personal Care Services. You have been getting 15.5 hours per week. A new personal care assessment was done on 2/20/2024. The assessment assigns time and task (based on your ability to do your daily activities).

Based on the results, it has been decided that the right number of hours is to be 6.25 hours per week. This will be a reduction in your current Personal Care services.

We made this decision because:

- of information given in addition to what our clinician observed during the assessment
- you are able to drive a car and use the steering wheel
- you are able to use your walker around the home, coming in/out of your front door

*Exhibit A, page 19*

8. Petitioner then filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, pages 34-38).
9. On May 8, 2024, Respondent sent Petitioner a Notice of Appeal Decision in which it stated that Petitioner's appeal was denied. (Exhibit A, pages 40-48).
10. With respect to the reason for the denial, the notice stated:

According to the PCA, which was completed in person, the assigned care coordinator observed, and the member reported functional status

improvements and the usage of adaptive equipment with Activities of Daily Living (ADLs) domains Toileting and Bathing, resulting in a decrease in time allotted for hands-on assistance.

Additionally, the ADL Grooming domain as well as the Instrumental Activities of Daily Living (IADLs) domains Meal Prep, Laundry & Housekeeping were reported to be previously over authorized resulting in a decrease in time allocated for hands-on assistance, therefore, in keeping with Medicaid Provider Manual, MI Health Link, Sections 5.1.D. the allocated time given was modified to meet the member's observed and reported need.

*Exhibit A, pages 40-41*

11. On June 13, 2024, MOAHR received the request for hearing filed in this matter. (Exhibit A, pages 2-5).

#### CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

As discussed above, Petitioner has been authorized for Personal Care Services through Respondent pursuant to the MI Health Link program. With respect to that program in general and Personal Care Services in particular, the applicable version of the Medicaid Provider Manual (MPM) states in part:

#### SECTION 1 — GENERAL INFORMATION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.

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## **SECTION 5 - COVERED SERVICES**

MI Health Link offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services and hearing aid coverage
- Dental services
  - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.
- Long Term Supports and Services (LTSS)
  - Nursing facility services
  - State Plan personal care services
  - Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.
  - MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD

- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

### **5.1 STATE PLAN PERSONAL CARE SERVICES**

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services may also be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.

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### 5.1.B. ASSESSMENT REQUIREMENTS

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for **MI** Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The face-to-face, comprehensive assessment is the basis for determining and authorizing the amount, scope and duration, and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration, and payment of services. The reassessment must be face-to-face.

ADLs and IADLs are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale, where 1 is totally independent and 5 requires total assistance.

<b>Independent</b>	The individual performs the activity with no human assistance.
<b>Verbal assistance</b>	The individual performs the activity with verbal assistance such as reminding, guiding or encouraging.
<b>Minimal human assistance</b>	The individual performs the activity with some direct physical assistance and/or assistance technology.
<b>Moderate human assistance</b>	The individual performs the activity with a great deal of human assistance and/or assistive technology.
<b>Dependent</b>	The individual does not perform the activity even with human assistance and/or assistance technology.

An individual must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater. In addition, the individual must have an ADL functional ranking of three (3) or greater to be eligible for IADL services. Once an individual is determined eligible for personal care services, his/her authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

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#### 5.1.D. REASONABLE TIME AND TASK

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an individual, so these are case maximums. When an individual's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the individual's record.

*MPM, April 1, 2024 version  
MI Health Link Chapter, pages 1, 5-7*

Here, Petitioner has been approved for 15.5 hours per week of Personal Care Services through Respondent; Respondent decided to reduce Petitioner's services to 6 hours per week; and Petitioner requested an administrative hearing with respect to that decision.

In appealing, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in deciding to reduce his services. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, Petitioner has met that burden of proof and the Respondent's decision must therefore be reversed.

Petitioner credibly and fully testified regarding Petitioner's continuing need for 15.5 hours per week of Personal Care Services, particularly given Petitioner's worsening health and lack of improvement in functioning. He also specifically disputed findings made by the Care Coordinator following the assessment regarding Petitioner's ability to use stairs, transport himself places, and interest in a wheelchair.

Moreover, while the assessment report provided by Respondent identified grounds for a reduction, that report is completely unsupported as the Care Coordinator who completed it no longer works for Petitioner and did not testify at the hearing, and the witnesses at the hearing had no personal knowledge of Petitioner's needs.

Additionally, while the assessment report is thorough, it is also directly contradicted by Petitioner's credible testimony and the parties identified at least one inaccuracy in the report regarding Petitioner's interest in a wheelchair, with the report stating that he declined a wheelchair while the parties agreed during the hearing that they are working toward securing Petitioner a wheelchair.

Accordingly, given Petitioner's credible and uncontradicted testimony, the undersigned Administrative Law Judge finds that Respondent erred in deciding to reduce Petitioner's Personal Care Services and its decision to do so must be reversed.

#### **DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly decided to reduce Petitioner's Personal Care Services.

**IT IS, THEREFORE, ORDERED** that:

Respondent's decision is **REVERSED**, and it must initiate a reassessment of Petitioner's services.