ISSUE

Did Respondent properly reduce Petitioner's home 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 organization that contracts with the Michigan Department of Health and Human Services ("MDHHS" or "Department") and oversees PACE in Petitioner's geographical area.

2. Petitioner is a REDACTED year-old woman who has been diagnosed with, among other conditions, chronic restrictive lung disease, with a dependence on oxygen; a history of fractures to her lower extremities; chronic pain syndrome; type 2 diabetes mellitus with neuropathy; coronary artery disease; hypertension; degenerative joint disease with lumbar spine stenosis; a history of falls; hyperlipidemia; hypothyroidism; gastroesophageal reflux disease; anxiety; depression; Raynaud's phenomenon; anemia; systemic inflammatory response syndrome; psoriasis; arthritis; chronic insomnia; irritable bowel syndrome; and osteoporosis. (Exhibit #4, page 1; Exhibit A, pages 34, 37-41).

3. In September of 2022, Petitioner enrolled in PACE through Respondent. (Testimony of Petitioner; Testimony of Respondent's Director of Clinical Operations).

4. Around that time, Respondent authorized her for 23 hours per week of home care services. (Exhibit #2, pages 1-3; Testimony of Respondent's Director of Clinical Operations).

5. Specific assistance included help with showering 2 times a week; dressing 2 times a day; hair care 1 time a day; emptying commode 2 times a day; housekeeping 3 times a week; decluttering 3 times a week until

Petitioner's home was decluttered; meal preparation 2 times a day; shopping 1 time a week; laundry 3 times as week; linen changes 2 times a week; and prosthetics 2 times a day. (Exhibit #2, pages 1-2).

6. In December of 2022, following Petitioner undergoing multiple surgeries on her lower extremities, Respondent increased Petitioner's home care services to 42 hours per week. (Exhibit #3, pages 1-2; Exhibit #5, pages 1-2; Exhibit A, pages 8-10; Testimony of Respondent's Director of Clinical Operations).

7 Specific assistance included help with a bed bath 2 times a week; dressing 2 times a day; hair care 1 time a day; oral care 2 times a day; toileting 2 times a day; incontinence 4 times a day; transferring 4 times a day; housekeeping 3 times a week; decluttering 3 times a week, until Petitioner's home was decluttered; meal preparation 2 times a day; shopping 1 time a week; laundry 3 times as week; linen changes 2 times a week; supervision 160 minutes per day; and prosthetics 2 times a day. (Exhibit #3, pages 1-2).

8. On March 5, 2024, an LPN with Respondent completed a semi-annual assessment with Petitioner. (Exhibit A, pages 14-19).

9. As part of that assessment, she utilizes a Home Care Assessment Tool. (Exhibit #4, pages 1-4; Exhibit A, pages 14-19).

10. During the assessment, she noted that Petitioner required hands-on assistance with her Activities of Daily Living (ADLs) and was dependent on others for housekeeping, laundry, showers, meal preparation, dressing lower body, and linin change. (Exhibit A, page 14).

11. She also found Petitioner to be independent in transferring, using a bedside commode/toileting, and hair and skin care. (Exhibit A, page 14).

12. She further found that Petitioner used a wheelchair but spent days in bed and had a shower or bed bath once every 1-2 weeks. (Exhibit A, pages 14-15, 17).

13. In the Home Care Assessment Tool, she found that Petitioner should be authorized for assistance with a shower or bed bath 1 time a week; dressing 1 time per day; application of lotion 2 times a week; a bed pan 1 time per day; housekeeping 3 times a week; decluttering 1 time a week; meal preparation 2 times a day; shopping 1 time a week, with Petitioner's store noted to be a significant distance from her rural home; laundry 2 times a week; and linen changes 1 time a week. (Exhibit A, pages 17-18).

14. On March 7, 2024, and March 8, 2024, Petitioner was also reassessed by her primary care physician (PCP), an occupational therapist (OT), a

physical therapist (PT), a social worker, and a registered dietitian. (Exhibit A, pages 20-56).

15. During those assessments, Petitioner was found to be independent in transferring and toileting by the OT and PT, and to be independent in wheelchair mobility by the OT, PT and PCP. (Exhibit A, pages 20-29, 33)

16. On March 29, 2024, Respondent's interdisciplinary team (IDT) met and discussed Petitioner's case. (Exhibit A, pages 6-7).

17. That same day, Respondent also sent Petitioner written notice that her home care hours would be reduced to 15 hours per week on April 8, 2024. (Exhibit A, pages 4-5).

18. With respect to the reason for the denial, the notice stated:

> The reason for this action is based on your home care evaluation that you are demonstrating more independence with tasks and activities of daily living. The legal basis for this decision is 42 CFR Part 460

Exhibit A, page 4

19. Petitioner subsequently requested an Internal Appeal with Respondent regarding the reduction in her services. (Exhibit A, page 57).

20. On April 18, 2024, Respondent sent Petitioner written notice that, following review of her Internal Appeal, it had been determined that the reduction in services would be upheld. (Exhibit A, pages 64-65).

21. With respect to the reason for the decision, the notice stated:

> The reason for this action is due to the PACE services being provided are sufficient for the participants' [sic] care and recommend that homecare hours be spread out 7 days a week with 2-hour visits. The legal basis for this decision is 42 CFR Part 460.

Exhibit A, page 64

22. On July 11, 2024, MOAHR received the request for hearing filed by Petitioner in this matter regarding Respondent's decision to reduce her home care services. (Exhibit A, page 66).

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.

PACE services are available as part of the Medicaid program, and with respect to the program and eligibility for it, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> SECTION 1 - GENERAL INFORMATION
>
> The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.
>
> *PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:*
>
> - Enhance the quality of life and autonomy for frail, older adults;
> - Maximize the dignity of, and respect for, older adults;
> - *Enable frail, older adults to live in the community as long as medically and socially feasible; and*
> - Preserve and support the older adult's family unit.
>
> The PACE capitated benefit was authorized by the federal Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.
>
> *An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult*

day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)

SECTION 2 - SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

*The **PACE** organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary.* **Services must include, but are not limited to:**

- **Adult day care that offers nursing, physical, occupational, and recreational therapies, meals, nutritional counseling, social work, and personal care**
- **All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care**
- **Interdisciplinary assessment and treatment planning**
- **Home health care, personal care, homemaker, and chore services**

- Restorative therapies
- Diagnostic services
- Transportation for medical needs
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care

MPM, January 1, 2024 version
PACE Chapter, pages 1-2
(Italics added for emphasis)

Here, Petitioner has been approved for PACE services at all times relevant to this matter; and it is only a reduction in her home care services that is in dispute.

In appealing the reduction to her services, Petitioner, citing rules from other jurisdictions, argues that the burden of proof in this case should be on Respondent because Respondent is reducing Petitioner's benefits and changing the status quo.

The Medicaid program is a cooperative federal-state partnership, and its basic requirements are governed by federal law. 42 USC 1396-1396v; 42 CFR 430.0 - 456.725. However, the burden of proof at a Medicaid administrative hearing is not addressed in the applicable statute or regulations.

In Michigan, there is also no case law directly on point; and Michigan's Administrative Procedures Act is silent on the issue of burden of proof. Generally, in Michigan Medicaid administrative hearings, the burden of proof has been placed on Petitioners to prove by a preponderance of evidence that they are entitled to the benefits they are seeking, regardless of whether the Agency is reducing or terminating previously

authorized benefits.' In support, Michigan has relied on the Supreme Court decision in *Lavine v Milne,* which holds that applicants for most government benefits "bear the burden of showing their eligibility in all respects." *Lavine v Milne,* 424 US 577, 582-583 (1976). Michigan also relies on *Blue Cross Blue Shield v Milliken,* 422 Mich 1; 367 NW2d 1 (1985), which holds generally that the party requesting the hearing or initiating the action: in this case the Petitioner has the burden of proof.

Accordingly, while the burden of proof issue is not settled law in Michigan, especially when the Agency is taking an action that is a reduction or termination of a previously authorized Medicaid covered benefit, the undersigned AU finds that Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred.

Given the record and available information in this case, Petitioner has failed to meet her burden of proof and Respondent's decision must, therefore, be affirmed.

As a preliminary matter, the undersigned AU would note that while Petitioner is appealing the reduction of her homecare services from 43 hours per week to 15 hours per week, Petitioner's arguments and evidence were primarily focused on comparing the reduced hours to Petitioner's hours when she was first approved for PACE, i.e., 23 hours per week of homecare services.

However, whatever Petitioner's circumstances were when she was first approved, and regardless of whether her needs at that time exceed her current needs, a past approval of 23 hours per week and general testimony about Petitioner worsening since that approval are not persuasive here given that Petitioner completely failed to demonstrate why 43 hours per week of homecare services are currently medically necessary or why some sort of reduction was in error.

Moreover, even comparing Petitioner's current authorization of 15 hours per week of homecare services to the 23 hours per week she was authorized in the past, Petitioner's arguments and testimony are still unpersuasive.

Petitioner's witnesses testified, and her representative argued that Petitioner's health has worsened; and her functioning decreased since she enrolled in PACE. In particular, Petitioner has since developed new medical conditions and undergone a number of surgeries on her lower extremities. She is now utilizing a wheelchair as opposed to a walker, and she is generally weaker and slower.

However, as testified to by Respondent's Director of Clinical Operations, the existence of new or changing medical conditions, even if part of a general worsening of health, does not necessarily require a greater need for care. For example, while Petitioner is

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As a matter of practice, Michigan ALJs have traditionally required the Agency to present its evidence first in all Medicaid administrative hearings so that the Petitioner is clear on what action the Agency has taken and why the Agency has taken such action. In this way, a Petitioner is not left to guess what the Agency's intentions are before presenting his or her case. However, that order of proceedings does not affect the burden of proof.

now in a wheelchair due to the worsening condition of her lower extremities and is unable to get her wheelchair into the bathroom due to its size, she instead independently uses a commode, which her caregiver empties once a day and takes less time for the caregiver than assisting Petitioner into the bathroom and toileting there.

Additionally, that general testimony about Petitioner's health worsening and her needs increasing, fails to demonstrate any specific errors by Respondent or any identifiable areas where Petitioner requires additional time than what is not authorized. In contrast, Respondent's documentation and witnesses credibly detailed what and why reductions were made in specific areas based on the reassessments with Petitioner only having a bed bath or shower once a week; needing less assistance with dressing, her commode/bed pan, decluttering, laundry, and linens; and no longer requiring any assistance with oral care, hair care, toileting, transferring, or supervision.

Moreover, with respect to the specific reductions in this case, many of the arguments made in Petitioner's hearing brief regarding how much or how often Petitioner needs assistance with tasks, including claims about how often Petitioner needs assistance with dressing, changing linens, laundry, decluttering or supervision, were not corroborated by any subsequent evidence or testimony by Petitioner or her former caregiver. And, while Petitioner did testify at one point that contrary to what was found by Respondent that she receives bathing twice a week, her testimony on that issue was also inconsistent; it was not clear if that was a recent change; and the undersigned ALJ does not her credible.

Petitioner also testified, along with presenting some medical documentation regarding changes that have occurred since the decision at issue in this case, and, to the extent that Petitioner has updated or new information to provide regarding her need for additional homecare services; then she can always request additional services again in the future along with that information. With respect to the decision at issue in this case, however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent's properly reduced Petitioner's services.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**