[redacted]
MI [redacted]

Date Mailed: February 10, 2020
MOAHR Docket No.: 19-013125
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on February 5, 2020. Petitioner appeared on her own behalf. Nicole Sandstrom, R.N., Clinical Services Manager for Upper Peninsula Health Plan (UPHP), appeared on behalf of Respondent (Department). Kathleen Peterson, R.N., Case Manager for UPHP and Jessica Sermen, Clinical Services Manager for UPHP, appeared as witnesses for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did Department properly deny Petitioner's request for additional Home Care hours through the Program of All-Inclusive Care for the Elderly (PACE)?

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 is an organization that contracts with the Michigan Department of Health and Human Services (MDHHS or Department) and oversees the PACE program in Petitioner's geographical area.

2. Petitioner is Medicaid beneficiary receiving services through the Department. (Exhibit A, p 1; Testimony.)

3. On September 1, 2019, Petitioner enrolled in the Department's MI Health Link program. (Exhibit A, p 1; Testimony.)

4. Prior to enrollment with the Department, Petitioner received home care services through Aetna Better Health of Michigan in the amount of 20 hours per week. (Exhibit A, pp 1, 2, 28-29; Testimony.)

5. On September 25, 2019, a referral was initiated for home care services. (Exhibit A, pp 1, 11; Testimony.)

6. On October 2, 2019, a personal care assessment was completed in Petitioner's home. During the assessment, Petitioner indicated she was independent with eating; able to toilet herself; able to transfer in and out of the tub using a transfer bar; will utilize a chair while bathing and only eats one meal a day Petitioner. As a result of the assessment, Petitioner was assigned a rank of 1 for eating, toileting, and meal preparation. Assigned a rank of 2 for medication. Assigned a rank of 3 for bathing, grooming, dressing, transferring, and mobility. Assigned a rank of 4 for shopping and housework. And assigned a rank of 5 for laundry. (Exhibit A, pp 1, 13-17; Testimony.)

7. On October 4, 2019, the Department received a copy of the assessment completed on October 2, 2019. Based on the assessment, the Department approved home care services for the following time and tasks:

Bathing	8 Hours per month
Grooming	No time since no help was needed
Dressing	3 Hours per month
Transferring	2 Hours per month
Mobility	No time since no help is needed
Shopping	7 hours per month
Housework	6 Hours per month
Laundry	7 Hours per month[1]

8. On October 15, 2019, the Department sent Petitioner a Notice of Denial of Coverage letter. The letter indicated the Department was reducing Petitioner's personal care services effective December 1, 2019.

[1] See Exhibit A, pp 1, 19-20.

Specifically, the notice indicated:

> You had a personal care review on October 2, 2019. Based on your needs, you are approved for a total of 33 hours per month of personal care services, for the following date range: December 31, 2019 to December 31, 2020. Your previous time of 20 hours per week will continue until December 31, 2020. Then your time will reduce to 33 hours per month…
>
> This decision is based on the Minimum Operating Standards for MI Health Link Program and MI Health Link Home and Community Based Service Waiver. (Exhibit A, pp 19-20.)

9. On November 26, 2019, the Department received an appeal letter from Petitioner requesting additional hours for home care services. Petitioner's appeal indicated she needed additional hours for bathing, dressing, walking, doctor's appointments, medication reminders, cooking, cleaning, laundry, grooming and general reminders. (Exhibit A, pp 1, 25-29; Testimony.)

10. On December 4, 2019, the Department sent Petitioner a Notice of Appeal Decision. The notice stated the following:

> We denied your appeal for the service/item listed above because:
>
> Your appeal was reviewed by the Upper Peninsula Health Plan (UPHP) Chief Quality Officer and the Clinical Services Manager – Care Management, who are both Registered Nurses. Review of your personal care assessment done on October 2, 2019 shows:
>
> You were already approved for the maximum time for shopping, laundry and housework (light cleaning) despite others living with you.
>
> You were already approved for bathing, which includes help washing your hair.
>
> You were already approved for help with dressing.
>
> Reminders to order medications and supplies are not a personal care benefit.
>
> Reminders to take medications are not a personal care benefit.

> Lifting your walker/wheelchair up and down stairs is not a personal benefit.
>
> Making sure you get to your appointments and setting up rides is not a personal care benefit.
>
> Time for getting to the doctor's office is not a personal care service benefit.
>
> The documentation at the time of your personal care assessment was clear. It stated that you only eat one meal per day and that you are independent (able to make it yourself). It also stated that your bath aide helps you comb your hair, but other times you do not need help. It stated that you do not need help with mobility (help with stairs and walking) or using your walker/wheelchair.
>
> It also showed that you are able to go to the bathroom without needing help.
>
> A review of the level of care assessment showed that you do not need help with bed mobility (how you move to and from lying position, turning form side to side and position body in bed), toileting (how you use the toilet room (or commode/bedpan) getting onto or off of the toilet, cleaning up, changing underwear, adjusting clothes) and eating. (Exhibit A, pp 43-52.)

11. On December 19, 2019, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for 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.

PACE services are available as part of the Medicaid program:

> 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 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, including laboratory, x-rays, and other necessary tests and procedures
- 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

Medicaid Provider Manual (MPM),
PACE Chapter, pp. 1-2
July 1, 2019, version

The Department's witnesses testified that the home care services were based on the assessment conducted on October 2, 2019. And that following the assessment, the Department determined that Petitioner's personal care services should be reduced as

there was an insufficient basis to grant additional hours above and beyond what was determined to be medically necessary to meet the Petitioners daily needs.

In this matter, the Petitioner bears the burden of proving by a preponderance of the evidence that Department erred in determining Petitioner's allocation of home care hours. Based on the above testimony and evidence, this Administrative Law Judge finds that Petitioner has failed to meet this burden of proof. Here, the Department conducted a comprehensive in-home assessment with Petitioner to determine her need for home care and properly determined that a reduction in that care was appropriate.

During the hearing, Petitioner identified a couple areas of potential need that according to the Department was not clearly communicated to them during the assessment. The Department indicated that based on this information, they were willing to conduct a new assessment to determine Petitioner's current need and allocation.

Accordingly, I find the Petitioner has failed to meet their burden of proof and that the Department properly determined Petitioner's home care hours.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined Petitioner's home care hours.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact	Managed Care Plan Division CCC, 7th Floor Lansing, MI 48919
Petitioner	[redacted] MI
Community Health Rep	Upper Peninsula Health Plan 853 W. Washington St Marquette, MI 49855