[redacted]
[redacted], MI [redacted]

Date Mailed: July 8, 2020
MOAHR Docket No.: 20-002353
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Steven Kibit**

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 18, 2020. Petitioner appeared and testified on her own behalf. [redacted], Petitioner's daughter, was also present, but did not testify as a witness. Charmaine Gee, Director of Appeals and Grievances, appeared and testified on behalf of Respondent AmeriHealth Caritas. Ronneshia Carter, Director of Long-term Services and Supports, also testified as a witness for Respondent. Dr. Thomas Petroff, Chief Medical Officer; Heather Hoonhout, Clinical Supervisor; Karen Curl-Spetney, Director of Medical Management; and Yismell Lopez, Appeals Specialist; were present for Respondent, but did not testify as witnesses.

During the hearing, Petitioner's Request for Hearing was entered into the record as Exhibit #1, pages 1-2. No other exhibits were admitted.

## ISSUE

Did Respondent properly deny Petitioner's request for additional 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 has been enrolled in the MI Health Link program and authorized for services through Respondent.

3. As part of her services, Petitioner has been approved for 56 hours per week of Community Living Supports (CLS); lawn care; and snow removal.

4. Respondent has also referred for Petitioner for services through other resources, including assistance with behavioral health and gaining skills to help independently manage her legal blindness, but Petitioner has declined such services.

5. Petitioner did request expanded CLS through Respondent in order to have personal care services twenty-four hours a day, seven days a week.

6. Respondent denied the request and, after Petitioner filed an Internal Appeal with Respondent, upheld that denial.

7. On April 15, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to that decision.

## 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 services through Respondent pursuant to the MI Health Link program. With respect to that program, 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.

* * *

## 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 . . .

* * *

### 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.

* * *

**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.

| | |
|---|---|
| **Independent** | The individual performs the |

| | |
|---|---|
| | activity with no human assistance. |
| **Verbal assistance** | The individual performs the activity with verbal assistance such as reminding, guiding or encouraging. |
| **Minimal human assistance** | The individual performs the activity with some direct physical assistance and/or assistance technology. |
| **Moderate human assistance** | The individual performs the activity with a great deal of human assistance and/or assistive technology. |
| **Dependent** | 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).

* * *

**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.

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**5.1.F. REIMBURSEMENT AND RATES**

After enrollment and according to the requirements of the three-way contract, the ICO must maintain the individual's current personal care providers and amount, scope and duration of services until the IICSP is reviewed and updated and providers are secured with individual approval. An ICO should use the Medicaid Home Help Payment Schedule to continue paying providers as scheduled. (Refer to the Directory Appendix for additional information.) An ICO should follow this schedule until the ICO and personal care provider agree upon a new payment schedule, which should be defined in the contract between the ICO and the personal care provider. The ICO must publish a pay cycle and must pay these claims on the next available pay cycle date.

Furthermore, an ICO should use the Individual and Agency County Rates to determine payment rates for the transition period until the ICO and personal care provider agree upon a rate that is defined in the ICO and personal care provider contract. (Refer to the Directory Appendix for additional information.)

After the transition period, payment rates for personal care services are established by the ICO. Tasks are assigned minute values which are converted to hours and billed as a total at the end of the ICO's preferred pay period. Reimbursement is subject to any state or federal laws that may be applicable in the future.

A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADLs, except for administering medications) and responsible relatives able and available to assist.

> If the individual does not require the maximum allowable hours for IADLs, only the amount of time needed for each task shall be authorized. Assessed hours for IADLs (except medication administration) must be **prorated by one half** in shared living arrangements where other adults reside in the home as personal care services are only for the benefit of the individual. This does not include situations where others live in adjoined apartments, flats or in a separate home on shared property and there is no shared common living area. In shared living arrangements where it can be clearly documented that IADLs for the enrolled individual are completed separately from others in the home, hours for IADLs do not need to be prorated.
>
> *MPM, October 1, 2019 version*
> *MI Health Link Chapter, pages 5*-9

Here, Petitioner has been approved for 56 hours per week of personal care services through Respondent; Petitioner requested an increase to have services twenty-four hours a day, seven days a week; Respondent denied that request; and Petitioner requested an administrative hearing.

In support of Respondent's decision, its Director of Long-term Services and Supports testified that, following the most recent assessment, Petitioner was approved for 8 hours of personal care services per day due to her need for assistance as a result of her chronic pain, arthritis, high blood pressure, stage three kidney disease, underactive thyroid, and legal blindness. Respondent's Director of Long-term Services and Supports also testified that the RTS table it is required to use only assessed Petitioner at 26.6 hours per week, but that Respondent increased those hours based on Petitioner's specific needs. She further testified that Respondent referred Petitioner for services through other resources, including assistance with behavioral health and gaining skills to be more independent despite her legal blindness, but that Petitioner declined those services.

In response, Petitioner testified that, while she appreciates what Respondent has done for her, her health issues are 24/7 problems and that she needs care at all times. She also testified that she awakens during the night and that, while she tries not to wake her daughter up, she ends up needing help regardless. Petitioner further testified that she is only forty-seven years-old, but that she can feel her body deteriorating. At the request of the undersigned Administrative Law Judge, Petitioner also described a typical day and the help she needs throughout the day. She further asked that she be seen as a human being, and not just a case number.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her request for additional 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 failed to meet that burden of proof and the Respondent's decision must be affirmed.

Petitioner has been approved for a significant amount of services and, as Respondent's witness credibly explained, more services than called for in the RTS table Respondent is required by policy to use given her specific needs. Moreover, while Petitioner broadly testified about needing around-the-clock care, that general testimony is not supported by specific instances warranting additional services, let alone an increase to twenty-four hours per day of services, given Petitioner's approved services; Petitioner's flexibility in how she allocates her approved hands-on assistance; and the availability of other, previously-declined resources.

To the extent Petitioner has additional or updated information to provide regarding her need for additional services, she can always request such services again in the future. With respect to the issue in this case however, Respondent's decision is affirmed given the information available at the time.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for additional services.

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

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sb

**Steven Kibit**
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**

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**Community Health Rep**

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**Petitioner**

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