[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: July 12, 2021
MOAHR Docket No.: 21-001346
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on May 19, 2021. [redacted], Petitioner's Caregiver/Daughter, appeared and testified on Petitioner's behalf. Linda Frost, Chief Clinical Officer, appeared and testified on behalf of Respondent Region 3B Area Agency on Aging/Carewell Services Southwest. Danielle Everett, Registered Nurse(RN)/Supports Coordinator, and Jacqueline Wagner, Clinical Manager of Social Work, also testified as witnesses for Respondent.

During the hearing, Petitioner's Request for Hearing was admitted into the record as Exhibit #1, pages 1-32. Respondent also submitted one evidence packet that was admitted into the record as Exhibit A, pages 1-29, 31-63.[1]

Following completion of the hearing, the record was left open at Petitioner's request so that she could submit additional documentation and Respondent could submit a response to such documentation.

On June 2, 2021, Petitioner timely submitted additional documentation, which was then admitted as Exhibit #2, pages 1-6. Respondent did not file any response to that additional documentation and the record closed on June 18, 2021.

ISSUE

Did Respondent properly deny Petitioner's request for additional Community Living Supports (CLS)?

[1] Page 30 of the evidence packet was stricken from the record because Petitioner's representative had not received it and on the basis of relevancy.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary who has been diagnosed with a cerebrovascular accident (CVA); chronic obstructive pulmonary disease; hypertension; arthritis; hemiplegia; depression; and diabetes mellitus. (Exhibit A, pages 13, 36-37).

2. Due to her diagnoses and need for assistance, Petitioner has been enrolled in the MI Choice Waiver Program and receiving services through Respondent. (Exhibit A, pages 13-29; Testimony of Respondent's representative).

3. Following an assessment on May 27, 2020, Petitioner was approved for 40 hours per week of CLS, with Petitioner's representative/daughter as both her paid caregiver and an informal support. (Exhibit A, page 26).

4. In August of 2020, Petitioner was hospitalized for an infection. (Exhibit A, page 37).

5. In September and October of 2020, she was hospitalized due to complications with her G-tube. (Exhibit A, page 37).

6. She also had periodic stays in a nursing home. (Exhibit A, pages 37, 39).

7. On November 11, 2020, following Petitioner's discharge from a nursing home, Respondent completed another assessment of Petitioner. (Exhibit A, pages 31-47; Testimony of RN/Supports Coordinator).

8. The assessment was completed with Petitioner's representative by telephone due to the ongoing COVID-19 pandemic. (Exhibit A, page 32).

9. During that assessment, Petitioner's representative reported, and Respondent documented, that Petitioner was bed bound; she has pressure sores whose dressing needs to be changed daily and as needed; she needs to be repositioned every two hours; and she has a urinary catheter that needs to be emptied daily. (Exhibit A, pages 34, 40-42).

10. Petitioner's representative also reported that Petitioner is continent and cannot give notice of bowel movements, so she wears briefs that need to be changed several times a day. (Exhibit A, page 41).

11. Petitioner's representative further reported that Petitioner has a PEG tube that needs for be flushed 4 times a day with water. (Exhibit A, page 43).

12. Respondent also found, based on Petitioner's representative's reports, that Petitioner is totally dependent on others in the areas of meal preparation, housework, managing finances, managing medications, phone use, shopping, transportation, bed mobility, transferring, dressing, eating, toileting, personal hygiene, and bathing. (Exhibit A, pages 41-42).

13. Following that assessment, Respondent reauthorized Petitioner for 40 hours per week of CLS. (Exhibit A, page 44).

14. On November 30, 2020, Petitioner's representative requested 16 more hours per week of CLS for Petitioner. (Exhibit A, pages 10-11).

15. That request was approved, effective December 2, 2020, with the additional 16 hours of CLS to be provided by Petitioner's granddaughter. (Exhibit A, pages 8-10).

16. Petitioner was also approved for skilled therapies, including speech therapy, occupational therapy and physical therapy, at that time. (Exhibit A, page 11; Testimony of RN/Supports Coordinator).

17. A nurse from Ascension Home Care was coming into the home for Petitioner twice a month as well, and a home health aide twice a week. (Exhibit #2, page 6; Exhibit A, pages 4-5, 9).

18. Petitioner's speech therapy, occupational therapy and physical therapy were discontinued in December of 2020. (Exhibit A, page 9).

19. The nursing services and home health aide were continued. (Exhibit A, page 9).

20. In December of 2020, Petitioner's representative requested an additional 14 hours per week of CLS for Petitioner. (Exhibit A, pages 8-9; Testimony of Respondent's representative; Testimony of RN/Supports Coordinator).

21. On December 23, 2020, Petitioner's representative and the RN/Supports Coordinator with Respondent discussed Petitioner's needs over the telephone. (Exhibit A, page 7).

22. On January 4, 2021, the RN/Supports Coordinator also spoke with a representative of the nursing agency who provides services to Petitioner, with that representative indicating that Petitioner needs approximately 56 hours per week of hands-on care. (Exhibit #2, page 6; Exhibit A, page 6; Testimony of RN/Supports Coordinator).

23. On January 14, 2021, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that her request for additional CLS had been denied. (Exhibit A, pages 48-51).

24. The reason identified for the denial was that there had been no change in Petitioner's condition. (Exhibit A, page 48).

25. On March 22, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit #1, pages 1-26).

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. 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.

Petitioner is receiving 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 to the Michigan Department of Health and Human Services. Regional agencies, in this case Respondent, 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:
>
> (1) Case management services.
>
> (2) Homemaker services.
>
> (3) Home health aide services.
>
> (4) Personal care services.
>
> (5) Adult day health services
>
> (6) Habilitation services.
>
> (7) Respite care services.
>
> (8) 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.
>
> (9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

42 CFR 440.180(b)

The Medicaid Provider Manual (MPM) outlines the governing policy for the MI Choice Waiver program and, with respect to services in general and CLS in particular, the applicable version of the MPM states in part:

> **SECTION 4 – SERVICES**
>
> The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:
>
> - indicated by the current assessment;
> - detailed in the person-centered service plan; and
> - provided in accordance with the provisions of the approved waiver.

Services must not be provided unless they are defined in the person-centered service plan and must not precede the establishment of a person-centered service plan. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

MDHHS and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Where applicable, the participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

* * *

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 includes 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.

CLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in household activities, Activities of Daily Living (ADL), or routine household care and maintenance.

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

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

- Transportation from the participant's residence to medical appointments, 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 service 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.

MPM, January 1, 2021 version
MI Choice Waiver Chapter, pages 10, 11-13

Here, as discussed above, Respondent decided to deny Petitioner's request for an additional 16 hours per week of CLS.

In appealing the decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying that request. Moreover, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

Given the available information and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed.

Petitioner undisputedly has significant needs, but she is also approved for a significant amount of services and the record reflects that Respondent properly took into account Petitioner's specific care needs when authorizing services and based its decision on the information provided by Petitioner's representative during the most recent assessment and during a subsequent telephone call.

Moreover, while Petitioner's representative testified that Respondent failed to take into account all of Petitioner's needs and that its documentation contains errors, much of what she testified to was discussed in Respondent's assessment or progress notes and, even if some information is missing or incorrect, none of the minor errors or discrepancies she identified appears to warrant additional CLS services. For example, the letter from the nursing agency that Petitioner provided after the hearing only confirms what Respondent documented, *i.e.,* that the nursing agency only reported to Respondent that Petitioner needs approximately 56 hours per week of hands-on care, and, even if the nursing agency misunderstood what Respondent meant by hands-on care, Respondent properly relied upon what it was told.

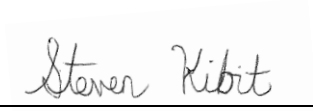
To the extent Petitioner has additional or updated information to provide regarding her need for services, she can always request more services again in the future. With respect to the denial at issue in this case however, Respondent's decision is affirmed given the information available at the time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

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:

The Respondent's decision is **AFFIRMED**.



SK/sb

Steven Kibit
Administrative Law Judge

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
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