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

Date Mailed: December 21, 2021
MOAHR Docket No.: 21-004286
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 December 14, 2021. [redacted], Petitioner's sister, appeared and testified on behalf of Petitioner. Petitioner also testified as a witness on her own behalf. Alec Jacobs, Associate Director of Quality and Compliance, appeared on behalf of Respondent Senior Services, Inc. Kelly Yagiela, Social Worker/Supports Coordinator, and Jane Ruhl, Registered Nurse/Supports Coordinator, testified as witnesses for Respondent.

During the hearing, the following exhibits were admitted into the record:

Exhibit #1: Request for Hearing

Exhibit A: Nursing Notes

Exhibit B: Screening dated June 29, 2021

Exhibit C: Screening dated August 4, 2021

Exhibit D: Progress Notes

ISSUE

Did Respondent properly reduce Petitioner's Community Living Supports (CLS)?

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 [redacted] ([redacted]) year-old Medicaid beneficiary who has been diagnosed with arthritis, osteoporosis, severe scoliosis, seizure disorder, depression, cancer, and lupus. (Exhibit #1, page 15; Exhibit B, pages 1, 8-9).

2. Petitioner also had chronic pain in her back and neck that limits her movements. (Exhibit B, page 9).

3. Due to her diagnoses and need for assistance, Petitioner has been enrolled in the MI Choice Waiver Program and authorized for services through Respondent. (Exhibit D, pages 1-17).

4. Prior to the action at issue in this case, Petitioner's approved services included 59.5 hours per week of Community Living Supports (CLS). (Exhibit #1, page 7).

5. On April 14, 2021, a representative from HomeJoy of Kalamazoo, the direct provider of Petitioner's CLS, contacted Respondent and reported that, while the morning and lunch shifts were being fully utilized, the workers for Petitioner during the dinner shift were basically preparing dinner and then sitting around. (Exhibit D, pages 13-14).

6. On April 21, 2021, Petitioner reported to Respondent that she was frustrated with staffing shortages at HomeJoy of Kalamazoo, with the Supports Coordinator indicating that home care agencies across the state were experiencing shortages. (Exhibit D, page 13).

7. Respondent then requested that HomeJoy of Kalamazoo document each shift during the next three to four weeks. *Exhibit D, page 12).

8. HomeJoy of Kalamazoo subsequently provided information on shifts to Respondent. (Exhibit D, pages 6-12).

9. For the time period of April 21, 2021 to July 6, 2021, HomeJoy of Kalamazoo reported one instance of an aide working over the scheduled time by 1 unit; 37 units not being utilized due to an aide being late, leaving early, or calling in and there being a delay in getting a replacement; 14 units not being utilized due to tasks being completed and Petitioner letting aide go home early; and 11 units not being utilized due to shift shortening caused by a lack of staff/full coverage. (Exhibit D, pages 6-12).

10. HomeJoy of Kalamazoo also identified 3 days, involving a total of 18 units,

where the CLS was not utilized either because of a lack of coverage or Petitioner letting the aide go early. (Exhibit D, pages 9-10).

11. On June 28, 2021, Respondent also completed a telephone assessment with Petitioner. (Exhibit B, pages 1-18).

12. In both that assessment and in its progress notes, Respondent noted that Petitioner reported functional improvement as a result of consistent physical therapy. (Exhibit B, page 3; Exhibit D, page 7).

13. Respondent also wrote in both the assessment and notes that Petitioner only reported a limited, as opposed to extensive, need for assistance with transferring now. (Exhibit B, pages 3, 13; Exhibit D, page 6).

14. Respondent further wrote in the progress notes that Petitioner is now able to walk independently, but the assessment itself found that Petitioner needed limited assistance with locomotion. (Exhibit B, page 13; Exhibit D, page 6).

15. On July 8, 2021, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that, effective July 19, 2021, her CLS would be reduced from 59.5 hours per week to 35 hours per week. (Exhibit #1, pages 7).

16. With respect to the reason for the reduction, the notice stated:

> Your community living supports (CLS) with HomeJoy of Kalamazoo has been reduced from 59.5 hours per week to 35 hours per week due to the change in your care needs according to the assessment that was conducted on 6/28/2021. This change will become effective as of 7/19/2021.
>
> * * *
>
> The legal basis for this decision is 42 440.230 (d): The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. In compliance with the provisions of the contract between the Michigan Department of Health and Human Services and the Pre-Paid Ambulatory Health Plan, Senior Services Inc. agrees to administer the MI Choice program according to the Centers for Medicare and Medicaid Services approved Waiver

application and the Medicaid Provider Manual.

Exhibit #1, page 7

17. Petitioner then requested an Internal Appeal with Respondent regarding that decision. (Exhibit #1, page 9).

18. As part of that appeal, Petitioner included a July 20, 2021 letter from Dr. [redacted], M.D., in which he stated in part: "I and she are very unclear as to how the decision was made via telephone assessment when again [Petitioner] has worsened with mobility as well as bodily functions." (Exhibit #1, page 21).

19. Petitioner also included an August 2, 2021 letter from Dr. [redacted], M.D., in which he stated in part:

> I have cared for [Petitioner] for over a decade. During that time there has been a persistent decline in her ability to do ADLs and care for herself.
>
> * * *
>
> As mentioned above, I have seen no drastic improvement which would warrant a reduction in services. Instead, I feel that over time she has become weaker and less independent. I feel it is in the best interests of [Petitioner's] health and future that her services be maintained at past levels.

Exhibit #1, page 13

20. On August 4, 2021, Respondent also completed an in-person assessment with Petitioner. (Exhibit C, pages 1-18).

21. During that assessment, Respondent found that Petitioner maintains her functional level as a result of consistent physical therapy. (Exhibit C, page 3).

22. It also found that Petitioner requires extensive assistance with transferring and limited assistance with locomotion, with Petitioner no longer able to ambulate with her walker and being essentially wheelchair bound. (Exhibit C, pages 13-14).

23. On August 16, 2021, Respondent sent Petitioner a letter indicating that following review of the Internal Appeal, Respondent was upholding a reduction in her CLS to 45 hours per week. (Exhibit #1, page 9).

24. The letter also advised Petitioner that, if she disagreed with the decision, she could request a state fair hearing. (Exhibit #1, page 9).

25. On September 20, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit #1, pages 1-44).

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

As discussed above, Respondent decided to reduce Petitioner's CLS from 59.5 hours per week to 45 hours per week.

In appealing the decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. 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 record in this case, Petitioner has met that burden of proof and Respondent's decision must therefore be reversed.

Respondent's initial reassessment of Petitioner was based on a report from the agency provider that not all of the approved CLS hours were being utilized, which could support a finding that fewer hours were necessary if true. However, the subsequent reports provided by the agency provider to Respondent at Respondent's request fail to indicate a significant underutilization of CLS hours, with much more hours being missed due to staffing shortages or issues with coverage, and there is nothing in the record to support the reduction in this case for underutilization.

Similarly, while Respondent further indicated in the initial notice sent to Petitioner that the reduction was based on a change in Petitioner's care needs, the record likewise fails to support such a finding. For example, Respondent initially noted that Petitioner was now able to walk independently, but both of the assessments expressly found that Petitioner needed assistance with locomotion. Moreover, while Respondent initially found in a telephone assessment that Petitioner's consistent physical therapy had led to functional improvement and that Petitioner only needed limited assistance with transferring, the subsequent in-person assessment expressly found that Petitioner only maintains her functional level as a result of consistent physical therapy and that she still requires extensive assistance with transferring.

Additionally, Petitioner's treating physicians further provided letters describing Petitioner's worsening physical condition and ability to care for herself, while Petitioner's representative also credibly explained why Petitioner continues to need the amount of CLS previously approved.

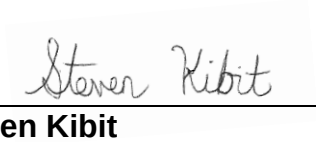
Accordingly, given the available information and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has met his burden of proof and Respondent's decision must therefore be reversed.

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 CLS.

IT IS THEREFORE ORDERED that:

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



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
Lansing, Michigan 48909-8139

DHHS -Dept Contact

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