[redacted]
C, MI [redacted]

Date Mailed: April 19, 2022
MOAHR Docket No.: 22-000781
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 March 29, 2022. [redacted], Petitioner's daughter, appeared and testified on Petitioner's behalf. Sarah Jacobs, Senior Manager of Regulatory Compliance and Quality Performance, appeared and testified on behalf of Respondent Area Agency on Aging 1-B. Molly Dobrzeniecki, Appeals and Audit Specialist, also testified as a witness for Respondent.

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

Petitioner's Exhibit:

Exhibit A: Request for Hearing

Respondent's Exhibits:

Exhibit #1: Assessment dated December 13, 2021
Exhibit #2: Progress Notes
Exhibit #3: Notice of Adverse Benefit Determination
Exhibit #4: Notice of Internal Appeal Extension
Exhibit #5: Notice of Internal Appeal Denial
Exhibit #6: Assessment dated March 7, 2022
Exhibit #7: ACE Home Care Network Training Documentation
Exhibit #8: Excerpts from Policy

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] year-old Medicaid beneficiary who has been diagnosed with congestive heart failure; hypertension; osteoporosis; anxiety; depression; multiple sclerosis; Parkinson's disease; seizure disorder; and diabetes mellitus. (Exhibit #1, pages 1, 9-10).

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 #1, pages 1-18).

3. As part of her services, Petitioner is approved for 39.25 hours per week of CLS. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

4. Specifically, the CLS was authorized for A.M. care and P.M. care, which includes dressing, bathing, *etc*.; medication reminders; escorts to meals; meal set-up, if meals are delivered to her room; toileting assistance; transferring assistance; behavior modification; generalized housekeeping; nightly checks; and diabetic management. (Testimony of Respondent's representative).

5. The direct service provider is Ace Care Network ("Ace"), the on-site provider at the home where Petitioner lives. (Exhibit #1, page 16).

6. On December 13, 2021, staff from Respondent completed a Full Assessment with Petitioner. (Exhibit #1, pages 1-18).

7. Petitioner's daughter was not present for the assessment. (Testimony of Petitioner's representative).

8. In part, that assessment found that Petitioner's diabetes is managed with prescribed medications and diet, with Ace staff checking her blood sugar and administering Petitioner's insulin for her. (Exhibit A, page 10).

9. On January 4, 2022, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that her CLS would be reduced by 10.5 hours per week. (Exhibit #3, pages 1-5).

10. With respect to the reason for the decision, the notice stated in part:

> The CLS services were previously approved relating to blood sugar management with the understanding that the participant was completing the tasks with supervision, not completion by a CLS worker, and that the Supports Coordinator will support the participant in obtaining a physician order for nursing services, due to participant's need for completion of blood sugar management.

> "MDHHS MI Choice Contract, Attachment H, Minimum Operating Standards for Community Living Supports, includes, “Reminding, cueing, observing, and monitoring of medication administration.” Minimum Operating Standards for Nursing Services, “Participants must meet at least one of the following criteria to qualify for this service: … Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.” And “In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services: a. Administering prescribed medications that the participant cannot self-administer (as defined under Michigan Complied Law (MCL) 333.7103(1)).”
>
> * * *
>
> Per the 12/13/2021 Re Enrollment, [Petitioner] reported that she is independent with transfers. This was confirmed by The Medical team.

Exhibit #3, pages 2-3

11. On December 30, 2021, Petitioner requested an Internal Appeal with Respondent regarding that decision. (Exhibit #4, page 1).

12. Respondent subsequently sent Petitioner a Notice of Internal Appeal 14 day Extension stating that Respondent had applied for an extension of time for responding to Petitioner’s Internal Appeal because there was a need for additional information and the delay was in Petitioner’s best interest. (Exhibit #4, pages 1-2).

13. During that review period, Respondent requested and received information from Ace regarding its training for and provision of diabetic management. (Exhibit #7, pages 1-23; Testimony of Appeals and Audit Specialist).

14. On February 11, 2022, Respondent sent Petitioner a Notice of Internal Appeal – Denial. (Exhibit #5, pages 1-4).

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

> AAA 1B conducted a re-assessment on 12/13/21. As a result, [Petitioner] was notified of a decrease in CLS hours for transfer/escort assistance in the amount of 7 CLS hours per week and 3.5 CLS hours related to blood glucose monitoring and insulin injections. [Petitioner] and her daughter [Petitioner's representative] were notified of the recommended reduction of CLS hours. [Petitioner's representative] expressed concern regarding the reduction. Per file notes, [Petitioner's representative] indicated that she was not involved in the re-assessment and hence the information given by [Petitioner] may not have been totally accurate.
>
> An internal appeal was filed 12/30/21 with all services remaining in place until the appeal is resolved.
>
> On 1/12/22, the internal appeal decision maker contacted [Petitioner] for her testimony. [Petitioner] requested that we speak with her daughter [Petitioner's representative] for additional information. On 1/12/22 [Petitioner's representative] was contacted to discuss the appeal and obtain her testimony.
>
> During testimony, [Petitioner's representative] indicated that [Petitioner] no longer had an issue with the transport/escort. She reported that [Petitioner] is able to manuver [sic] her power wheel chair and is able to get to the dining room without assistance. [Petitioner's representative] also addressed concern with the patient wandering and the need for nightly checks. [Petitioner's representative] admitted that the nightly checks were not consistently [sic] done. She also stated that [Petitioner's] medications have been adjusted, the wandering was no longer an issue. There have not been any fall reported, [Petitioner] has a PERS that she is able to use in an emergency situation. [Petitioner's representative] did testify

that the 7 hours of CLS service in place for transfers/escort was no longer necessary.

Per [Petitioner's representative], the bigger concern was the blood glucose monitoring and insulin injections. [Petitioner] is currently on a daily dose of Insulin along with a sliding scale dosage based on blood sugars(BS) that are tested 4 times per day. Currently, [Petitioner] is unable to do her own BS testing or administer her own insulin due to her tremors and dementia. [Petitioner's representative] stated that those services were being provided by ACE- a home care company that [Petitioner's representative] was very happy with.

The internal appeals decision maker contacted ACE and spoke with Star. Star testified that a Med Tech was providing the BS monitoring and insulin injections under the CLS hours. Documentation was requested to support that the Med Tech was licensed/certified to provide these service. Initial documentation submitted did not contain all the information required to meet the contract requirements as documented in the manual. A 14 day extension was implemented on 1/21/22 so that all necessary documentation from ACE could be obtained prior to an appeal decision. AAA 1B staff reached out to ACE again, indicating exactly what was required to support that the BS monitoring and insulin administration was within the Mi Choice contract guidelines. Attachment H- CLS Minimum Operating Standards:

11.Each direct service provider who chooses to allow staff to assist participants with self-medication, as described in 2.c above, must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum: a. The provider staff authorized to assist participants with taking their own

prescription or over-the counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. c. Instructions for entering medication information in participant files. d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self administration of medications.

12.CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158: a. A provider must only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable. b. A provider must assure that medication use conforms to federal standards and the standards of the medical community. c. A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment. d. A provider must review the administration of a psychotropic medication periodically as set forth in the participant's individual PCSP and based upon the participant's clinical status. e. If an individual cannot administer his or her own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained. f. A provider must record the administration of all medication in the recipient's clinical record. g. A provider must ensure that staff report medication errors and adverse drug reactions to the participant's physician immediately and properly and record the incident in the participant's clinical record.

> Upon review of all documentation received on 2/7/22 and review of a med tech scope of practice(SOP) in Michigan it was determined that the 3.5 CLS hours allotted for Diabetic management is not with in the contract guidelines nor the SOP for a med tech.
>
> Due to [Petitioner's] ongoing need for Diabetic management, 3.5 hours per week of Nursing service have been approved.

Exhibit #5, pages 1-3

16. On February 17, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to the decision to reduce Petitioner's services. (Exhibit #1, pages 1-15).

17. Petitioner's CLS have continued to be approved in the amount of 39.25 hours per week while this matter has been pending. (Testimony of Respondent's representative).

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, 2022 version
MI Choice Waiver Chapter, pages 10, 11-13

Moreover, regarding providers of such services, the MPM also states:

SECTION 9 – PROVIDERS

Authorization for provision of waiver services is the responsibility of the waiver agencies. They determine the status of the qualifications and certifications (if applicable) for

all direct service providers, negotiate and enter into contracts with the providers, and reimburse providers.

9.1 ENROLLMENT OF SERVICE PROVIDERS

Waiver agencies must use written contracts meeting the requirements of 42 CFR 434.6 to purchase services. Entities or individuals under subcontract with the waiver agencies must meet provider standards defined in the Minimum Operating Standards for MI Choice Waiver Program Services which is maintained by MDHHS and attached to each annual waiver agency contract. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

To ensure network capacity, as well as choice of providers, each waiver agency must have a provider network with capacity to service at least 125% of their monthly slot utilization for each MI Choice service and at least two providers for each MI Choice service. When waiver agencies cannot ensure this choice within 30 miles or 30 minutes travel time for each participant, they may request a rural area exception from MDHHS.

MPM, January 1, 2022 version
MI Choice Waiver Chapter, page 34

Additionally, with respect to CLS services, the Minimum Operating Standards for MI Choice Waiver Program Services referenced in the above policy states in part:

2. Community Living Supports (CLS) include:

a. Assisting, reminding, cueing, observing, guiding and training in the following activities:

   i. Meal preparation
   ii. Laundry
   iii. Routine, seasonal, and heavy household care and maintenance
   iv. Activities of daily living such as bathing, eating, dressing, and personal hygiene
   v. Shopping for food and other necessities of daily living

b. Assistance, support, and guidance with such activities as:

i. Money management
ii. Non-medical care (not requiring nursing or physician intervention)
iii. Social participation, relationship maintenance, and building community connections to reduce personal isolation
iv. Transportation from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence
v. Participation in regular community activities incidental to meeting the individual's community living preferences
vi. Attendance at medical appointments
vii. Acquiring or procuring goods and services necessary for home and community living

c. Reminding, cueing, observing, and monitoring of medication administration

d. Staff assistance with preserving the health and safety of the individual in order that he or she may reside and be supported in the most integrated independent community setting.

e. Training or assistance on activities that promote community participation, such as using public transportation or libraries, or volunteering.

f. Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan.

g. Observing and reporting to the supports coordinator any changes in the participant's condition and the home environment.

3. When the CLS services provided to the participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.i, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, 2.d, or 2g above, the individual furnishing CLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and experience with

food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

4. When the CLS services provided to the participant include tasks specified in 2.a.iv, 2.b.ii, 2.c, 2.d, 2.e, 2.f, or 2.g above, the direct service providers furnishing CLS must also:

a. Be supervised by a registered nurse (RN) licensed to practice nursing in the State. At the State's discretion, other qualified individuals may supervise CLS providers. For licensed residential settings, persons employed as facility owners or managers qualify to provide this supervision. The direct care worker's supervisor must be available to the worker at all times the worker is furnishing CLS services.

b. Develop in-service training plans and assure all workers providing CLS services are confident and competent in the following areas before delivering CLS services to MI Choice participants, as applicable to the needs of that participant: safety, body mechanics, and food preparation including safe and sanitary food handling procedures.

c. Provide an RN to individually train and supervise CLS workers who perform higher-level, noninvasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for each participant who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

d. MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant training course, first aid, and CPR training.

* * *

10. The waiver agency or provider agency must train each worker to perform properly each task required for each participant the worker serves before delivering the service to that participant. The supervisor must assure that each worker

> competently and confidently performs every task assigned for each participant served.
>
> *Minimum Operating Standards*
> *Attachment H*

As discussed above, Respondent decided to reduce Petitioner's CLS from 39.25 hours per week to 28.75 hours per week, with the reductions related to assistance with transferring and diabetic management specifically.

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 essentially undisputed record in this case, Petitioner has failed to meet her burden of proof and Respondent's decision must therefore be affirmed. For example, while Petitioner continues to have significant needs, Petitioner's representative expressly agreed during the hearing that Petitioner is independent in transferring.

Moreover, both parties agree that Petitioner still requires assistance with diabetic management, and it is just a question of who would provide those services, with Petitioner appealing the reduction in CLS and Respondent approving 3.5 hours per week of nursing service in place of the removed CLS hours.

Respondent is responsible under the above policies for ensuring that workers are properly trained. In this case, its witnesses credibly and fully testified regarding the findings that the CLS workers at Ace were not sufficiently trained or supervised in the area of diabetic management, and how, consequently, they cannot be approved to provide such assistance as CLS.

Petitioner does not challenge that testimony and, instead, her representative testified how the assistance with diabetic management is still needed. However, the medical necessity of the assistance is undisputed, and Respondent has approved nursing services in lieu of the CLS hours previously authorized for diabetic management.

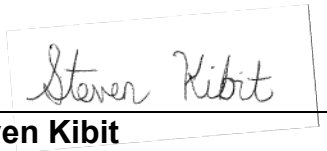
Accordingly, reviewing the decision at issue in this case, *i.e.,* the reduction in CLS services, the undersigned Administrative Law Judge finds that Respondent's decision was proper given Petitioner's medical needs and the authorization of alternative services. In making that finding, the undersigned Administrative Law Judge would again note that the assistance with diabetic management remains medically necessary and must be provided.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly decided to reduce Petitioner's CLS.

IT IS THEREFORE ORDERED that:

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



Steven Kibit
Administrative Law Judge

SK:tem

NOTICE OF APPEAL: Petitioner 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 Department Rep.

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Petitioner

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