GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
DIRECTOR

[redacted]
[redacted] MI[redacted]

Date Mailed: July 22, 2024
MOAHR Docket No.: 24-005028
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 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on July 10, 2024. Matthew Nagaj, Attorney, appeared on behalf of Petitioner. [redacted] Petitioner's daughter, appeared as a witness for Petitioner. Sarah Jacobs, Compliance Officer, represented Respondent AgeWays (Respondent). Molly Docrzeniecki, Appeals and Audit Analyst; and Samantha Oulch, Social Worker, testified as witnesses for Respondent.

Exhibits:

Petitioner	1.	Medical Record
	2.	Emails
	3.	Emails
	4.	Assessment
	5.	Assessment
	6.	Medical Record
Respondent	A.	Hearing Summary

ISSUE

Did Respondent properly reduce Petitioner's Community Living Supports (CLS) and terminate Petitioner's use of a Personal Emergency Response System (PERS)?

FINDINGS OF FACT

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

1. As of February 26, 2024, Petitioner was approved for 48 hour per week of CLS and the use of a PERS.

2. On February 26, 2024, an assessment was conducted with the Petitioner. During the assessment, it was reported Petitioner's dementia had worsened but, there was no documentation to indicate worsening behavioral symptoms. It was also reported Petitioner was a fall risk, but there were no documented falls. Petitioner was reported to attend dialysis 3 days a week for 3.5 hours per session (10.5 hours per week); Physical therapy (at home); and Silver Club. Petitioner's daughter reported Petitioner requires a specialized diet, but that meals were still prepared together for both of them and that Petitioner needs some assistance with daily routine activities.[1]

3. Following the assessment, the Respondent determined Petitioner's CLS hours should be reduced to 30.25 hours per week and Petitioner no longer met the eligibility requirements for a PERS.

4. On April 3, 2024, the Petitioner filed an Internal Appeal.

5. On April 26, 2024, a review was conducted regarding the reduction of CLS and the denial of a PERS. Following the review, it was determined Petitioner was only utilizing 40 hours of the 48 approved CLS hours.

6. On May 2, 2024, Respondent sent Petitioner two Notices of Internal Appeals upholding the decision to reduce CLS from 48 hours per week to 30.25 hours per week and terminate the PERS. The notices stated in particular:

> Time sheets (from 3/1/24 to present) were requested from [redacted] the vendor that employs [redacted] as the umbrella worker for [redacted] There are two different sheets completed for each week. The Client/Patient Care Flow Sheet captures date, time services rendered, tasks completed. The participant and employee both sign this page. The second sheet, Daily Pertinent Observations and/or Comments has a space for each day of the week and the participant and employee both initial this page. There is

[1] Petitioner can feed herself, toilet, dress, and ambulate with minimal assistance or through the use of assistive devices i.e. walker. (Exhibit A, p 11-12.)

also an area for Mileage and in this case the mileage has been authorized so the area needs to be completed. There are multiple concerns related to the documentation received including but not limited to multiple corrections to time and/or task, illegible documentation, mileage odometer reading was not reported and the Daily Pertinent Observation form states the same comment repeatedly. Reporting that participant had a "good day and was in a good mood" is not pertinent information.

Also, there is no care listed for Saturdays. [redacted] reported that there are no other family members to assist with care. Based on [redacted] testimony of [redacted] cognitive decline and no other caregiver – either formal or informal it is unclear as to why the current 40 hours per week being billed by [redacted] is not spread out over 7 days instead of six days. Current authorization is for 48 hours per week however it was confirmed with the vendor that [redacted] would not be allowed to work 48 hours per week, that 40 hours per week is the maximum. Based on documentation and utilization review, 48 hours per week of CLS services were not needed to support [redacted] evidenced by 40 hours per week being billed consistently. In addition, the time calculated for weekly tasks based on the testimony, documentation, chart review and [redacted] assessed needs, supports 30.25 hours weekly of CLS services.[2]

During testimony, [redacted] reported that [redacted] has some cognitive decline; however, the iHC done on 2/26/24 does not support this. [redacted] reports that [redacted] needs assistance to use the cell phone that [redacted] currently ahs; however, [redacted] is able to call [redacted] on it if needed. [redacted] reported that [redacted] can't dial 911. When asked if [redacted] had ever been taught to dial 911 or how to access emergency services on a cell phone, which is often a one step process, [redacted] responded, "no". Furthermore, [redacted] reported the PERS would be nice to have if something happened while [redacted] was alone. Per the 2/26/2024 iHC, it was reported that [redacted] is home alone less than 1 hour per day. Upon additional questioning, [redacted] stated that there may be 6 hours per week that [redacted] is by herself, confirming what was reported in the iHC. [redacted] also reported that should [redacted] be left alone, there are camara monitors in the house. [redacted] is at dialysis 3 days per

[2] Exhibit A, p 12.

> week and [redacted] transports her to and from dialysis. She is also at Silver Club, currently one day per week, hoping to increase to 3 days per week. [redacted] is currently providing 40 hours per week of CLS services, and [redacted] works form home during the week from 12 noon to 8:30 pm.
>
> Edna does not qualify for the PERS. Per the Medicaid Provider Manual, 4.1.L. PERSONAL EMERGENCY REPONSE SYSTEM, Limitations – PERS is limited to persons who either live alone or who are left alone for significant periods on a routine basis and who could not summon help in an emergency without this device.[3]

7. On May 10, 2024, the Michigan Office of Hearings and Rules received from Petitioner, a request for hearing.

8. At all times relevant to this proceeding, Petitioner resided with her Provider [redacted] (Testimony.)

9. At all times relevant to this proceeding, [redacted] worked 12:00 pm through 8:30 pm. (Testimony.)

10. At all times relevant to this proceeding, Petitioner had a monthly cell phone bill of $100. (Exhibit A, p 70.)

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 beneficiaries. Waivers allow exceptions to State plan requirements and permit a State to implement

[3] Exhibit A, pp 15-16.

> innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of beneficiaries 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.[4]

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.[5]

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.[6]

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:

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[4] 42 CFR 430.25(b).
[5] 42 CFR 430.25(c)(2).
[6] 42 CFR 440.180(b).

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 authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. 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, waiver agencies, and direct service providers must 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.

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort. The participant's preference for a certain

provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The waiver agency must deem the chosen provider capable of performing the required tasks.

For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.

Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.

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4.1.D. COMMUNITY LIVING SUPPORTS

Definition	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. These services are provided 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.
Requirements	CLS includes: ▪ Assisting, reminding, cueing, observing, guiding and/or training in: ➢ Activities of Daily Living (ADL) such as bathing, eating, dressing, personal hygiene, toileting,

	transferring, etc. * ➢ Laundry and other household activities ➢ Non-medical care (not requiring nurse or physician intervention) * ➢ Meal preparation (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, seasonal, and heavy household care and maintenance ➢ Attendance at medical appointments ➢ Participation in regular community activities incidental to meeting the individual's community living preferences. ▪ Reminding, cueing, observing or monitoring of medication administration.* ▪ Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's PCSP.*

	▪ Staff assistance with preserving the health and safety of the participant in order that they 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.* As applicable to the tasks being performed, the direct service provider 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. When the CLS services provided to the participant include tasks identified with an asterisk (*) above, the direct service providers furnishing CLS must also: ▪ Be supervised by a RN licensed to practice nursing in Michigan. 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. ▪ Develop in-service training plans and ensure 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. ▪ Provide an RN to individually train and supervise CLS workers who perform higher-level, non-invasive 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 ensure each worker's confidence and competence in the performance of each task required. ▪ MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant (CNA) training course, first aid, and CPR training. When the CLS services provided to the participant include transportation, the following standards apply: ▪ Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants. ▪ All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy. ▪ The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies unless expressly prohibited by a labor contract or insurance policy. ▪ Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage. ▪ When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant. Individuals providing CLS must be at least 18 years old, and able to communicate effectively both orally and in writing and follow instructions. Members of a participant's family may provide CLS to the participant. However, waiver agencies must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse. Family members who provide CLS must meet the same

	standards as providers who are not related to the participant. 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 ensure that each worker competently and confidently performs every task assigned for each participant served. Each direct service provider who chooses to allow staff to assist participants with self-medication 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: ▪ 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. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ 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. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158: ▪ 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.

	▪ A provider must ensure that medication use conforms to federal standards and the standards of the medical community. ▪ A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment. ▪ A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status. ▪ If a participant cannot administer their own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained. ▪ A provider must record the administration of all medication in participant's clinical record. ▪ 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. CLS provided in a residential setting like assisted living, Adult Foster Care, or Homes for the Aged, includes only those services and supports that are in addition to, and must not replace, usual and customary supports and services furnished to residents in the licensed setting. CLS does not include the costs associated with room and board. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS. Homemaking tasks incidental to the provision of assistance with ADL may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure. When CLS services are provided to the participant under a self-determination arrangement, the individual furnishing CLS must also be trained in cardiopulmonary resuscitation. This training may be waived when the provider is furnishing services

	to a participant who has a “Do Not Resuscitate” order. These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.
Limitations	CLS does not include the costs associated with room and board. When transportation incidental to the provision of CLS is included, the waiver agency must not also authorize transportation as a separate waiver service for the participant. CLS excludes nursing and skilled therapy services. The phrase “These services are provided 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” included in the definition of this service shall be interpreted as follows: ▪ All informal supports must agree to provide the uncompensated (informal) services and supports to the participant as specified in the PCSP. Specifically, the record must show the following: ➢ All persons providing informal services and supports included on the PCSP are aware of and capable of performing the tasks assigned to them for the benefit of the participant as included in the person-centered service plan. ➢ All informal supports agree to any financial liability related to the informal services and supports assigned to them on the person-centered service

	plan. This includes uncompensated or voluntary transportation of the participant. ➢ Supports coordinators or other waiver agency staff did not arbitrarily assign the completion of services and supports that could otherwise be included as CLS to informal supporters. Rather, both the participant (or their responsible party) and the informal support agree in writing (by their signature on the person-centered service plan) to the provision of the identified services and supports as discussed during a person-centered planning meeting. Relatives, caregivers, landlords, community or volunteer agencies, or other third-party payers have been contacted on behalf of the participant and agree to provide services and supports to the participant because they are both capable of and responsible for the provision of the identified services and supports. This agreement is noted by an authorized signature on the person-centered service plan from a representative of the entity identified as responsible for the services and supports.

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4.1.L. PERSONAL EMERGENCY RESPONSE SYSTEM

Limitations	PERS does not cover monthly telephone charges associated with phone service. PERS is limited to persons who either live alone or who are left alone for significant periods on a routine basis and who could not summon help in an emergency without this device. Waiver agencies may authorize PERS units for persons who do not live alone if both the participant and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. The supports coordinator must clearly document in the case record the reason for provision of a PERS.[7]

[7] MPM, MI Choice Waiver Chapter, April 1, 2024, pp 19, 23-27, 39-40.

Here, as discussed above, Respondent has decided to reduce Petitioner's CLS from 48 hours per week to 30.25 hours per week and the discontinuance of a PERS pursuant to the above policies.

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 and applicable policies in the case, the Petitioner has failed to meet her burden of proof; and the reduction and termination of services must; therefore, be affirmed.

The record is clear in that Petitioner needs services; and, furthermore, that the prior allocation of 48 hours was not being fulfilled and was limited by the 40 hours per week allegedly provided by Petitioners daughter. The documentation provided by the Provider Agency and Petitioner's Provider is questionable as pointed out by the Respondent and does call into question the actual services being rendered/provided and what is medically necessary. Further exasperating these problems is the fact Petitioner's provider works a full-time job during intervals when Petitioner's Provider is alleged to be providing care and at the same time as Petitioner is alleged to be in need of care. This also coincides with the documentation reflecting Petitioner as not requiring/needing care on Saturdays.

In regard to the need for a PERS unit, Petitioner acknowledged the device was being used as a communication device as it amplified sounds and made it easier to communicate with Petitioner. It was further undisputed that Petitioner lives with her Provider and is left alone for very limited periods of time that do not exceed an hour. As a result, a PERS device does not meet the requirements found in the MPM.

To the extent Petitioner's needs have changed or she and her representatives have additional information to report, then they can always request additional services again in the future with that updated information. With respect to the decision at issue in this case; however, Respondent's decision must be affirmed given the available information and applicable policies.

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 and terminate Petitioner's PERS.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED.**

CA/pe

Corey Arendt
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

Via Electronic Mail and First Class Mail:

Petitioner and Authorized Hearing Representative

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

Via Electronic Mail:

Counsel for Petitioner
Matthew J. Nagaj
15851 S. US 27, Ste. 73
Lansing, MI 48906
Mnagaj@meji.org

Community Health Representative
Ageways
Lori Smith
29100 Northwestern Hwy Ste 400
Southfield, MI 48034
Lsmith@AgeWays.org

DHHS Department Representatives
Heather Hill
MDHHS
400 S. Pine, 5th Floor
Lansing, MI 48933
HillH3@michigan.gov