[redacted]
[redacted] MI [redacted]

Date Mailed: July 5, 2024
MOAHR Docket No.: 24-005265
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 June 20, 2024. [redacted] Petitioner's daughter, appeared and testified on Petitioner's behalf. Sarah Jacobs, Compliance Officer, represented Respondent AgeWays (Respondent). Molly Docrzeniecki, Appeals and Audit Analyst, testified as a witness for Respondent.

During the hearing, the following exhibits were entered into the record without objection:

Petitioner's Exhibit:

Exhibit A: Request for Hearing

Respondent's Exhibits:

Exhibit #1: Notice of Adverse Benefit Determination

Exhibit #2: Notice of Appeal Decision

Exhibit #3: Assessment dated March 4, 2024

Exhibit #4: Assessment dated May 16, 2024

Exhibit #5: Medicaid Provider Manual, Section 4.1.D.

Exhibit #6: Medicaid Provider Manual, Section 4.5

Exhibit #7: Medicaid Provider Manual, Section 4.1.N.

Exhibit #8 Medicaid Provider Manual, Section 4.1.K

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, among other conditions, vascular dementia; congestive heart failure; hypertension; arthritis; renal failure; syncope; and age-related physical debility. (Exhibit #3, pages 1, 11-13).

2. She requires around-the-clock care, including total care for activities of daily living and instrumental activities of daily living, and she is not left alone at home. (Exhibit #3, pages 6-7, 19-24).

3. Due to her diagnoses and need for assistance, Petitioner has been enrolled in the MI Choice Waiver Program and receives services through Respondent. (Exhibit #3, pages 1-30).

4. As part of her services, Petitioner was approved for 72 hours per week of CLS. (Exhibit #3, page 2; Testimony of Appeals and Audit Analyst).

5. Specifically, a CLS worker provided care from 8:30 a.m. to 4:30 p.m. on Mondays through Fridays while Petitioner's representative provided both the remaining 32 hours of CLS as a paid caregiver and all other care required as an informal support. (Testimony of Petitioner's representative).

6. Petitioner was also sleeping from 9:00 p.m. to 7:00 a.m. each night. (Testimony of Petitioner's representative; Testimony of Appeals and Audit Analyst).

7. On March 4, 2024, Respondent completed a routine reassessment of Petitioner's needs and services. (Exhibit #3, pages 1-30).

8. During that assessment, Respondent found that Petitioner continued to be dependent on others for all her activities of daily living and instrumental activities of daily living. (Exhibit #3, pages 6-7, 19-24).

9. Respondent also found that Petitioner continued to sleep through the night, but that she now needed to be fed by a caregiver and her memory and cognition had been declining since the last assessment. (Exhibit #3, pages 9, 16, 18).

10. On March 28, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that, effective April 6, 2024, her CLS would be reduced from 72 hours per week to 62 hours per week. (Exhibit #1, pages 1-9).

11. With respect to the reason for the reduction, the notice stated in part:

> The clinical documentation provided does not establish medical necessity.
>
> Participant's Community Living Services will be reduced from 72 hours per week to 62 hours per week based on participants identified needs and the assessment conducted on 3/4/24[.]

Exhibit #1, page 9

12. On April 5, 2024, Petitioner requested an Internal Appeal with Respondent regarding that decision. (Exhibit #2, page 1).

13. On April 12, 2024, Petitioner began receiving hospice care. (Testimony of Petitioner's representative).

14. On May 3, 2024, Respondent sent Petitioner a Notice of Internal Appeal – Denial. (Exhibit #2, pages 1-4).

15. In that notice, Respondent stated that it was upholding the reduction in CLS. (Exhibit #2, page 1).

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

> On 4/29/2024, the appeals analyst contacted [Petitioner's representative] for her testimony related to the appeal. [Petitioner's representative] reported that her mother was enrolled in a hospice program that included a nurse once a week, bath aide twice per week and social worker and clergy once per month. [Petitioner's representative] was informed that coordination of care between hospice and AgeWays clinical department is needed to avoid any duplication of services. [Petitioner's representative] voiced understanding. [Petitioner's representative] reported that [Petitioner] needed 24/7 care due to her declining health and dementia.
>
> [Petitioner's representative] reported that [Petitioner] has a care giver that provides 8 hours of Community Living Support (CLS) services, Monday – Friday for a

total of 40 hours per week. The remaining 32 hours per week [Petitioner's representative] provides formal care as an umbrella worker. She also provides all the informal care [Petitioner] needs. [Petitioner's representative] reported that she is exhausted and wants some respite due to her own advanced age and health concerns.

[Petitioner's representative] reported that she makes the meals and does shopping for her mother who is on a soft, cardiac, low sodium, sugar free diet. Fluid intake is monitored however there are no restrictions in place. [Petitioner] sits at the table in her wheelchair for meals. Her ability to feed herself has decreased. [Petitioner's representative] reported that [Petitioner] is no longer using utensils however she can feed self some finger foods. [Petitioner] is reported to have some choking episodes from food and/or her own saliva. Further, [Petitioner] is reported to have syncopal episodes 2-3 times per week and can happen during a meal. Therefore, at mealtime, the caregiver sits with [Petitioner] to provide immediate care for choking and syncopal episodes.

On 3/4/2024, service hour determination was based on [Petitioner] receiving one shower per week, two full bed baths per week and 7 days a week of partial bed bath. Per testimony, [Petitioner's representative] reported that [Petitioner] was no longer having a weekly shower. The showering process has become more difficult related to [Petitioner's] inability to bear weight and was physically exhausting her. Currently, [Petitioner] receives 2 full bed baths per week along with 5 days per week of partial bed bath as reported by [Petitioner's representative].

[Petitioner] is assisted to a bedside commode by the caregiver and using a Sit to Stand device. [Petitioner] is incontinent of bladder and bowel and [Petitioner's representative] reported [Petitioner] is no longer wheeled to the bathroom related to the process being fatiguing for [Petitioner]. Assistance to the commode and/or incontinence garments are reported to be happen every 2-3 hours during daytime hours. Personal hygiene is provided with the assistance of the Sit to Stand however with [Petitioner's] increasing

> leg weakness it has become a more difficult, time-consuming task. [[Petitioner] has a powered Hoyer Lift that is used for bed to wheelchair transfers, including AM, PM and 2 naps. [Petitioner] is no longer able to self-propel her wheelchair. She requires her caregiver to move her from room to room and to the table at mealtimes.
>
> Following PM care, [Petitioner's representative] reported that [Petitioner] is put in bed between 9:00-10:00 PM. [Petitioner] will position her and make sure she is comfortable on the air mattress. [Petitioner] does not receive care through the night until approximately 8:30-9:00 AM when the caregiver arrives. It was reported that [Petitioner] may wake up during the night and start conversing related to her dementia. [Petitioner's representative] reported that [Petitioner] may reposition herself or scoot a little bit in the bed during the night but however she was positioned at nighttime is the position she wakes up in. [Petitioner's representative] and [Petitioner] live together, and [Petitioner's representative] will provide care if needed during the overnight hours. [Petitioner's representative] reported that [Petitioner's] physician is aware of the current overnight plan and is amendable to it.
>
> Based on testimony and chart review, the appeals team is upholding the clinical decision to decrease CLS hours for [Petitioner] from 72 hours per week to 62 hours per week. As [Petitioner's] condition changes, related to the progression of her disease processes, reassessment should be done to ensure that appropriate CLS services are authorized, discuss service delivery alternative to avoid care giver burn out and that care is coordinated with the hospice team.

Exhibit A, page 67

17. On May 13, 2024, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit A, pages 1-15).

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 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.
>
> *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 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.

.

* * *

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.

MPM, April 1, 2024 version
MI Choice Waiver Chapter, pages 19, 23-27

Here, as discussed above, Respondent has decided to reduce Petitioner's CLS from 72 hours per week to 62 hours per week 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, Petitioner has failed to meet her burden of proof and the reduction in services must therefore be affirmed.

Neither Petitioner's significant care needs nor the extensive assistance provided by Petitioner's paid and natural supports are disputed in this case. However, Respondent also demonstrated how a reduction in services was in order given Petitioner's decline, which Respondent's witness credibly explained lead to less time needed for feeding, bathing and toileting as Petitioner was participating less and the caregiver could work faster; reports that she continued to sleep through the night; and, as of the time of Internal Appeal decision, Petitioner's receipt of hospice care services.

Moreover, while Petitioner's representative generally disputed the reduction when it happened, her testimony at the hearing was limited to changes in Petitioner's circumstances since the decision at issue in this case, with hospice care now being provided on a different schedule; Petitioner going to bed later; Petitioner not responding as well to care; and Petitioner passing out more. However, as discussed above, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

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.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 5th day of July 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic & First Class Mail:

Petitioner
[redacted]
MI [redacted]
[redacted]

Authorized Hearing Representative
[redacted]
[redacted] MI [redacted]
[redacted]

Via Electronic Mail:

DHHS Department Representative
Heather Hill
MDHHS
Lansing, MI 48933
HillH3@michigan.gov

Community Health Representative
Ageways
Lori Smith
Southfield, MI 48034
Lsmith@AgeWays.org