Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

**Date Mailed:** April 10, 2025
**Docket No.:** 25-005884
**Case No.:** [redacted]
**Petitioner:** [redacted]

[redacted]
MI [redacted]

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**এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।**
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**Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.**

## DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed by Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on March 20, 2025. [redacted] the Owner and Chief Executive Officer of M&R Home Assistance, appeared and testified on Petitioner's behalf. Attorney Mark Kopson represented Respondent Aetna Better Health Premier Plan (Respondent), the Respondent Integrated Care Organization (ICO). Laquinda Bates, Manager of Clinical Services, and Dr. Tiffany Wedlake, Medical Director, testified as witnesses for Respondent.

During the hearing, Petitioner submitted two exhibits that were entered into the record without objection as Exhibits A-B. Respondent also submitted eight exhibits that were admitted into the record without objection as Exhibits #1-#8. No other proposed exhibits were submitted.

## ISSUE

Did Respondent properly decide to reduce Petitioner's Personal Care Services?

## FINDINGS OF FACT

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

1. Respondent is an Integrated Care Organization (ICO) contracted by the Michigan Department of Health and Human Services (Department or MDHHS) and the Centers for Medicare & Medicare Services (CMS) to provide covered services through the MI Health Link managed care program.

2. Petitioner is enrolled in the MI Health Link program and has been authorized for services through Respondent. (Testimony of Petitioner's representative; Testimony of Manager of Clinical Health Services).

3. As part of her services, Petitioner was approved for 36 hours per week of Personal Care Services. (Testimony of Manager of Clinical Health Services).

4. Those services were authorized following the completion of a Personal Care Assessment, in which Respondent's staff utilized the Michigan Home and Community Based Services (HCBS) Needs Tool, on July 6, 2024. (Exhibit #5, pages 1-9; Testimony of Manager of Clinical Health Services).

5. On November 11, 2024, Respondent's Case Manager completed a reassessment with Petitioner, again utilizing the same Michigan HCBS Needs Tool. (Exhibit #6, pages 1-9; Testimony of Manager of Clinical Health Services).

6. On January 13, 2025, Respondent sent Petitioner written Notice of Denial of Medical Coverage in which it stated that Petitioner's request for 36 hours per week of Personal Care Services had been denied and that, instead, only 19 hours per week of such services would be approved. (Exhibit A, pages 5-6; Exhibit #1, pages 1-10).

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

> You were previously approved for [Respondent] to cover 36 hours of Personal Care Services per week through the health plan Benefit [sic]. Records show that you require 19 hours of Personal Care Services per week, based on our assessment of your needs, and this amount is approved. Your assessment does not support the additional 17 hours of Personal Care Services per week you have requested to manage your care needs.

> Personal Care Services include:
> -bathing
> -walking
> -dressing
> -hair care
>
> Your services will be reduced to 19 hours of Personal Care Services per week beginning on 1/31/2025.

*Exhibit A, page 5*

8. Petitioner then filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, page 30).

9. On February 12, 2025, Respondent sent Petitioner a Notice of Appeal Decision in which it stated that Petitioner's appeal was denied. (Exhibit A, pages 33-37; Exhibit #2, pages 1-10).

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

> Based on the information we have about your medical condition, your medical history, and your current medical needs we are still not able to approve this request.
>
> We do not see that:
> - Your needs are not met with the nineteen (19) hours each week of Personal Care services you are receiving.

*Exhibit A, page 33*

11. On February 14, 2025, MOAHR received the request for hearing filed in this matter with respect to the decision to reduce Petitioner's personal care services. (Exhibit A, pages 1-37).

12. Petitioner's Personal Care Services have continued to be approved at 36 hours per week while this administrative matter is pending. (Testimony of Manager of Clinical Health Services).

## CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). 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.

As discussed above, Petitioner has been authorized for Personal Care Services through Respondent pursuant to the MI Health Link program. With respect to that program in general and Personal Care Services in particular, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 1 – GENERAL INFORMATION**
>
> Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.
>
> MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.

* * *

## SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services and hearing aid coverage
- Dental services
  - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.
- Long Term Supports and Services (LTSS)
  - Nursing facility services
  - State Plan personal care services
  - Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.
  - MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD
- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

## 5.1 STATE PLAN PERSONAL CARE SERVICES

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services may also be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.

* * *

## 5.1.B. ASSESSMENT REQUIREMENTS

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for MI Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The face-to-face, comprehensive assessment is the basis for determining and authorizing the amount, scope and duration, and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration, and payment of services. The reassessment must be face-to-face.

ADLs and IADLs are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale, where 1 is totally independent and 5 requires total assistance.

| | |
|---|---|
| **Independent** | The individual performs the activity with no human assistance. |
| **Verbal assistance** | The individual performs the activity with verbal assistance such as reminding, guiding or encouraging. |
| **Minimal human assistance** | The individual performs the activity with some direct physical assistance and/or assistance technology. |
| **Moderate human assistance** | The individual performs the activity with a great deal of human assistance and/or assistive technology. |
| **Dependent** | The individual does not |

| | |
|---|---|
| | perform the activity even with human assistance and/or assistance technology. |

An individual must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater.

In addition, the individual must have an ADL functional ranking of three (3) or greater to be eligible for IADL services. Once an individual is determined eligible for personal care services, his/her authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

* * *

**5.1.D. REASONABLE TIME AND TASK**

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an individual, so these are case maximums. When an individual's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the individual's record.

*MPM, January 1, 2025 version*
*MI Health Link Chapter, pages 1, 5-7*

Here, Petitioner has been approved for 36 hours per week of Personal Care Services through Respondent; Respondent decided to reduce Petitioner's services to 19 hours per week; and Petitioner requested an administrative hearing with respect to that decision.

In appealing, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in deciding to reduce her services. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, Petitioner has not met that burden of proof, and the Respondent's decision must therefore be affirmed.

The record in this case clearly identifies the basis for the reduction in this case, with Respondent's Manager of Clinical Health Services going through the two relevant assessments; detailing the specific findings that changed and indicate a lessened need for Personal Care Services; and the subsequent decision to reduce Petitioner's services. Respondent's Medical Director also testified, based on the information she was provided and reviewed, that the reduction was appropriate.

In response, Petitioner's representative, who is also the owner of the agency that provides her services, specifically testified why he believed the reduction was made in error, with not every aspect of Petitioner's needs accurately documented, whether as an oversight or due to language barriers. He also testified that Petitioner's medical conditions and diagnoses have not changed, but that she is now undergoing radiation treatments.

The positions of the parties are therefore clear, and the dispute turns on what was actually reported and evaluated during the most recent assessment. However, for both parties, their arguments on that issue rely on hearsay regarding what occurred, with no one who was present at the reassessment testifying during the hearing.

Moreover, given that limited evidence, Petitioner has failed to meet her burden of proof and Respondent's decision must be affirmed. Petitioner's diagnoses may be unchanged, but it is the effect of those diagnoses and Petitioner's need for assistance that are at issue; and Petitioner has failed to contradict Respondent's findings with any persuasive evidence or show any error.

Petitioner's evidence does suggest that Petitioner's health has changed since the decision in this case and, to the extent Petitioner has updated or additional information to provide, she can always request an increase in services in the future. 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 Personal Care Services.

**IT IS, THEREFORE, ORDERED** that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sj

**NULL**
Administrative Law Judge

**APPEAL RIGHTS:** Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

**Via First Class & Electronic Mail:**

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

**Via Electronic Mail:**

**Community Health Representative**
AETNA BETTER HEALTH OF MI
AETNA-GRIEVANCES AND APPEALS
28588 NORTHWESTERN HWY STE 380B
SOUTHFIELD, MI 48034
**COEGAREGULATORYREQUESTS@AETNA.COM**

**Respondent Representative**
MARK S. KOPSON
PLUNKETT COONEY
38505 WOODWARD AVE STE 100
BLOOMFIELD HILLS, MI 48304
**MKOPSON@PLUNKETTCOONEY.COM**

**Department Contact**
MDHHS-MANAGED CARE PLAN DIVISION
400 S PINE ST 7TH FL
LANSING, MI 48933
**MDHHS-MCPD@MICHIGAN.GOV**

**Via First Class Mail:**

**Petitioner**
[redacted]
MI [redacted]