STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2011-11475 EDW

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted] was present for the hearing. [redacted] with the [redacted] represented the Appellant. [redacted], and [redacted], appeared on behalf of the Department of Community Health. [redacted] is the MI Choice Waiver agent for the Michigan Department of Community Health.

ISSUE

Did the waiver agency properly terminate the Appellant's participation in the MI Choice Waiver program?

FINDINGS OF FACT

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

1. The Appellant is [redacted] participant in MI Choice Waiver Program.

2. His case was transferred from another agency and was opened by the Respondent on [redacted]. Since that time, the Appellant has been assessed five times by the waiver agency. (Testimony of [redacted])

3. The Appellant has multiple diagnoses, including paraplegia, diabetes, herpes zoster, and stage 3-4 pressure sores. (Respondent's Exhibit 3, pages 12-13; Testimony of [redacted])

4. The Appellant received the following services through the MI Choice Waiver Program: light housekeeping and medical transportation. (Testimony of

[redacted] Respondent's Exhibit 3, page 18)

5. On [redacted], the waiver agency completed its most recent re-assessment with the Appellant. (Respondent's Exhibit 3, pages 6-19)

6. On [redacted], the waiver agency also completed a Michigan Medicaid Nursing Facility Level of Care Determination (LOC determination). (Respondent's Exhibit 2)

7. The Appellant and the nurse/case manager signed the LOC determination on [redacted], indicating that the Appellant met the functional/medical eligibility criteria for Medicaid Nursing Facility Level of Care. (Respondent's Exhibit 2, page 8)

8. After the assessment, the Appellant's case was further reviewed by the waiver agency and it determined that the Appellant no longer qualified for services. More specifically, he did not qualify under Door 4 because he had never requested or received waiver services for wound care and he did not qualify under Door 7 because the services he was receiving from the waiver agency are available through the Department of Human Service's Home Help Services (HHS) Program. (Testimony of [redacted])

9. On [redacted], the waiver agency issued an Advance Action Notice to the Appellant, indicating that his waiver services were being terminated because the Appellant does not meet a nursing home level of care. (Respondent's Exhibit 3, page 21)

10. The Appellant requested a formal, administrative hearing on [redacted].

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 (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.

This Appellant is claiming eligibility for services through the Department's Home and Community Based Services for Elderly and Disabled (HCBS/ED). The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicare Services to the Michigan Department of Community Health (Department). Regional agencies, such as [redacted], 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)*

1915(c) (42 USC 1396n (c) allows home and community based services to be classified as "medical assistance" under the State Plan when furnished to recipients who would otherwise need inpatient care that is furnished in a hospital SNF, ICF or ICF/MR and is reimbursable under the State Plan. (42 CFR 430.25(b))

Effective November 1, 2004, the Michigan Department of Community Health (MDCH) implemented revised functional/medical eligibility criteria for Medicaid nursing facility, MI Choice, and PACE services. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria.

Section 4.1 of the Medicaid Provider Manual Nursing Facilities Section references the use of an online Michigan Medicaid Nursing Facility Level of Care Determination tool. *Michigan Medicaid Nursing Facility Level of Care Determination, March 7, 2005, Pages 1-9*. The assessment tool must be completed for all Medicaid-reimbursed admissions to nursing facilities or enrollments in MI Choice or PACE on and after November 1, 2004.

The assessment tool consists of seven service-entry doors. The doors are: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependency. In order to be found eligible for MI Choice Waiver services, the Appellant must meet the requirements of at least one door. The waiver agency presented testimony and documentary evidence that the Appellant did not meet any of the criteria for Doors 1 through 7.

Door 1
Activities of Daily Living (ADLs)

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.

(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:
- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

(D) Eating:
- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

Door 2
Cognitive Performance

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

Door 3
Physician Involvement

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3

1. At least one Physician Visit exam AND at least four Physicians Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physicians Order changes in the last 14 days.

Door 4
Treatments and Conditions

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories . . . and have a continuing need to qualify under Door 4.

In order to qualify under Door 4, the applicant must receive, within 14 days of the assessment date, any of the following health treatments or demonstrate any of the following health conditions:

A. Stage 3-4 pressure sores
B. Intravenous or parenteral feedings
C. Intravenous medications
D. End-stage care
E. Daily tracheostomy care, daily respiratory care, daily suctioning
F. Pneumonia within the last 14 days

G. Daily oxygen therapy
H. Daily insulin with two order changes in last 14 days
I. Peritoneal or hemodialysis

Door 5
Skilled Rehabilitation Therapies

Scoring Door 5: The applicant must have required at least 45 minutes of active ST [speech therapy], OT [occupational therapy] or PT [physical therapy] (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

Door 6
Behavior

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

1. A "Yes" for either delusions or hallucinations within the last 7 days.
2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

Door 7
Service Dependency

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency under Door 7.

More specifically, the applicant must be a program participant for at least one year and require ongoing service to remain current functional status. In addition, there must be "no other community, residential or informal services . . . available to the meet the applicant's needs."

Michigan Medicaid Nursing Facility Level of Care Determination, March 7, 2005, pages 1-9.

Here, there was no evidence presented to indicate that the Appellant would qualify under Doors 1, 2, 3, 5, or 6.

As to Door 4, the Appellant previously qualified for waiver services under this door. The waiver agency testified that at the most current assessment and LOC determination on [redacted] the nurse/case manager concluded that the Appellant continued to

qualify under Door 4 because he suffers from ongoing stage 3-4 pressure sores. However, it was later determined by the waiver agency that this was an error because the Appellant had never requested or received wound care services through the waiver program. The waiver agency asserted that a beneficiary cannot qualify under Door 4 if they do not require waiver services specific to that Door 4 condition. (Testimony of [redacted])

To support this assertion, the waiver agency referred this Administrative Law Judge to the LOC determination field definitions guidelines, which provide, in pertinent part, as follows regarding Door 4:

> Applicants will not qualify under Door 4 when the conditions have been resolved, or if they no longer affect functioning or the need for care. It is required that an active restorative nursing and discharge plan be developed and used as the focus for treatment. Unless otherwise notes, score each item for the last 14-day timeframe.
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> *Michigan Medicaid Nursing Facility Level of Care Determination, Field Definitions Guidelines, November 11, 1004, page 11 of 20.*

The waiver agency's nurse/case manager testified that, at the assessment, she looked at the Appellant's wounds and there was no redness, drainage, and odor present. She stated that the Appellant advised her that he cared for his wounds himself, and he did not express any interest in wound care service at that time, stating that he was "managing." (Testimony of [redacted] Accordingly, the waiver agency determined that the Appellant did not meet Door 4 because his pressure sores no longer affected his functioning or need for care.

The waiver agency further argued that even if the Appellant was in need of wound care services, that need alone would not qualify him for the waiver program. The waiver agency explained that because the Appellant has Medicare coverage and because Medicaid, and by extension the Waiver Program, is the payor of last resort, the Appellant would first have to seek wound care through Medicare, and if necessary, the waiver agency would only provide supplemental services. This position is supported by MI Choice Waiver Program policy, which directs that other paid services available to the participant must be taken advantage of and MI Choice funding is the payment source of last resort. *Michigan Department of Community Health Contract Requirements for Supports Coordination Service Performance Standards and MI Choice Program Operating Criteria, Attachment K, October 1, 2009, page 43 of 75.*

Conversely, the Appellant's representative argued that the Appellant only needs to meet one category of "physician-documented treatments and conditions" under Door 4 to meet eligibility criteria, and stage 3-4 pressure sores, which Appellant suffers from, is the first listed category. She stated that because of the waiver services, the Appellant has been able to live independently for the last several years, which is the goal of the Waiver Program.

The Appellant and his representative did not dispute that he had historically refused wound care services. However, the Appellant testified that he requested that a nurse be present at his [redacted] assessment to take a look at his wounds. The Appellant further submitted medical documentation dated [redacted] confirming that he has a need for wound care services. (Appellant's Exhibit 1, page 1)

There is no dispute that the Appellant has stage 3-4 pressure sores. There is also no dispute that he never received or requested wound care services from the waiver agency until after it terminated his services. The LOC determination requires that the applicant have "a continuing need" for services. Further, the field guidelines state that an applicant is not qualified if the condition "no longer affect[s] functioning or the need for care." Here, even though the Appellant suffered from the ongoing condition, at the time of the assessment, it was not affecting his functioning or his needs for care. Indeed, he conceded at the hearing that he was taking care of the pressure sores himself and that he had previously refused waiver services specific to his condition because of issues of privacy and embarrassment.

While the Appellant has since sought medical intervention and his physician has recommended that he be provided wound care services, the waiver agency did not have that information before it at the time it made its decision in this matter to terminate the Appellant's services. And this Administrative Law Judge is limited to considering evidence the waiver agency had at the time it made its determination in [redacted].

Moreover, as the waiver agency pointed out at the hearing, it is the payor of last resort. Therefore, it would not be primarily responsible for the Appellant's wound care given his Medicare coverage.

Finally, turning to Door 7, an applicant could qualify under Door 7 if he is currently (and has been a participant for at least one year) being served by either the MI Choice Program, PACE program, or Medicaid reimbursed nursing facility, requires ongoing services to maintain current functional status, and no other community, residential, or informal services are available to meet the applicant's needs.

The Appellant's representative argued that for purposes of continuity of service, the waiver agency should continue to provide the Appellant with services. She further stated that private-duty nursing is unique to the MI Choice Waiver program and that the Appellant would not be able to receive wound care through other programs. She also argued, and the Appellant testified, that the services received through the waiver agency were superior to those provided by the HHS program.

Here, the Appellant has been in the program for more than one year and he does require ongoing services to maintain his current functional status. However, the services that the Appellant is receiving—homemaking and non-medical transportation—are available through the HHS Program. Therefore, the Appellant does not satisfy the criteria for eligibility under Door 7.

The Appellant bears the burden of proving, by a preponderance of evidence, that the waiver agency did not properly terminate his MI Choice Waiver services. A preponderance of the material and credible evidence established that the MI Choice Waiver agency acted in accordance with the law and its contract with the Department, and its actions were proper when it terminated the Appellant's MI Choice Waiver services. While this Administrative Law Judge is sympathetic to the Appellant's circumstances, I do not have authority to override or disregard the policy set forth by the Department. The Appellant did not meet the nursing facility level of care.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the waiver agency properly terminated the Appellant's MI Choice Waiver services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/25/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.