STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2011-18590 EDW

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 et seq. upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] represented the Appellant. The Appellant was present and gave testimony.

[redacted] represented the Department's MI Choice Waiver Agency, [redacted], appeared as witnesses for the Department's MI Choice Waiver Agency.

ISSUE

Did the Department's Waiver Agency properly terminate Appellant from the MI Choice Waiver program?

FINDINGS OF FACT

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

1. The Department contracts with the waiver agency to provide MI Choice Waiver services to eligible beneficiaries.

2. The Appellant is an [redacted] woman with a history of cardiovascular problems including hypertension, and arthritis. (Exhibit 5).

3. The Appellant lives in an independent setting in the community. (Exhibit 5).

4. The Appellant receives Adult Home Help Services from (ACOA) and/or

Home Help Services through the Department of Human Services. (Exhibit 5, page 2; Exhibit 6).

5. The Appellant is/was also receiving case management and lifeline services through the Older Americans Act funding. (Exhibit 6).

6. In or before [redacted], the Appellant was considered for enrollment into MI Choice Waiver services from the waiver agency. (Exhibit 6). A person must meet a nursing facility level of care in order to be eligible for MI Choice Waiver services.

7. In or on [redacted], the waiver agency performed an assessment and a required level of care determination for the Appellant. (Exhibit 5).

8. During the required level of care determination the MI Choice Waiver social worker asked the Appellant questions and assessed that the Appellant's overall memory was okay, she was independent in her daily decision-making, and she could make herself understood. (Exhibits 1, 5).

9. During the full assessment the MI Choice Waiver nurse and social worker asked the Appellant questions, and observed the Appellant's abilities, and determined she could perform all her activities of daily living or had help with the activities of daily living through the adult home help services. (Exhibits 1, 5).

10. Based on the MI Choice Waiver agency in-person observations, that there was an ability to perform activities of daily living, and there were not enough physician visits, order changes or skilled therapy treatments, the MI Choice Waiver determined the Appellant was no longer eligible for MI Choice Waiver services.

11. The MI Choice Waiver funding is a payment source of last resort. The MI Choice Waiver must consider all available public benefits, community resources, third-party insurance coverages, or private pay services before it can authorize any MI Choice Waiver Service.

12. On [redacted], the Appellant was issued an Advance Action Notice. (Exhibit 3).

13. On [redacted], the Appellant's request for hearing was received in this hearings office. (Exhibit 9).

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 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 Medicaid (formerly HCFA) to the Michigan Department of Community Health (Department). Regional agencies, in this case an [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)*

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. *42 CFR 430.25(c)(2)*

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *42 CFR 440.230.* In order to assess what MI Choice Waiver program services are medically necessary and therefore Medicaid-covered, the MI Choice Waiver program performs periodic assessments.

The Michigan Department of Community Health (MDCH) utilizes the same 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.

The Medicaid Provider Manual, Nursing Facilities Coverages Section, July 1, 2009, lists the policy for admission and continued eligibility as well as outlines functional/medical criteria requirements for Medicaid-reimbursed nursing facility, MI Choice, and PACE services.

Section 4.1 of the Medicaid Provider Manual Nursing Facility Coverages Section references the use of an online Michigan Medicaid Nursing Facility Level of Care Determination Tool. The LOC is mandated for all Medicaid-reimbursed admissions to

nursing facilities or enrollments in MI Choice or PACE. A written form of the LOC, as well as field guidelines are found in the *MDCH Nursing Facility Eligibility Level of Care Determination, Pages 1-9, 3/07/05* and *MDCH Nursing Facility Eligibility Level of Care Determination Field Definition Guidelines, Pages 1-19, 3/15/05.*

The Level of Care Assessment Tool consists of seven service entry Doors. (Exhibit 1, Pages 19-25). 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 Medicaid Nursing Facility placement the Appellant must meet the requirements of at least one Door.

Door 1
Activities of Daily Living (ADLs)

LOC page 3 of 9 provides that the applicant must score at least six points to quality under Door I.

> **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

The LOC indicates that to qualify under Door 3 the applicant must

> …[M]eet either of the following to qualify under
>
> 1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR
> 2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

Door 4
Treatments and Conditions

LOC page 5 indicates that 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 demonstrated 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

LOC page 6 provides that the applicant must:

> …[H]ave required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5

Door 6
Behavior

An applicant must exhibit any of the following behavior symptoms during the 7 days before the assessment: Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, Resists Care. An applicant must exhibit any of the following Problem Conditions during the 7 days before the assessment: Delusions and Hallucinations. LOC page 8 provides that to

qualify under Door if the applicant must score under the following two options:

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

An applicant could qualify under Door 7 if there was evidence that she or he is currently being served in a nursing facility (and for at least one year) or by the MI Choice or PACE program, and required ongoing services to maintain her current functional status.

As part of the re-assessment the MI Choice Waiver team is required to assess the Appellant's ability to perform her activities of daily living. The MI Choice Waiver program assessment team performed an in-person assessment for the Appellant and determined that she could perform her activities of daily living independently. For that reason, the MI Choice assessment team determined that the Appellant could not qualify under door 1.

During the full assessment the MI Choice Waiver social worker care manager asked the Appellant questions and observed the Appellant. Based on the Appellant's answers, the MI Choice Waiver social worker, a professional experienced with assessing a person's mental status, assessed that the Appellant was able to make herself understood, was independent in decision-making and that overall the Appellant's memory was okay; therefore she was not eligible through door 2.

The MI Choice Waiver team ascertained that the Appellant did not have the number of physician visits or physician order changes to qualify under door 3.

MI Choice Waiver team noted that the Appellant did not have the treatments, skilled therapies, or behaviors to qualify under doors 4, 5, and 6.

With regard to door 7 the MI Choice Waiver team determined that the Appellant was not currently being served by MI Choice, PACE, or nursing facility, and had other services available such as home help services, and therefore did not qualify under door 7.

Based on the MI Choice Waiver assessment team's observations of the Appellant, and her answers to questions by the Appellant the MI Choice Waiver agency determined the Appellant was not eligible for the MI Choice Waiver.

The Appellant's witness testified that the Appellant has good days and bad days. The

Appellant's witness testified that the Appellant does not think to take her medications all the time and therefore needs medication monitoring. The Appellant's witness said sometime the Appellant needs to be checked on to make sure she is eating okay.

This ALJ and the MI Choice agency are bound by the federal regulations and state policy, and can not authorize services for which there is no documentation of medical necessity. This ALJ is limited to considering evidence the MI Choice agency had at the time it made its determination in [redacted]. In [redacted] the evidence the MI Choice Waiver agency showed that the Appellant was independent in her activities of daily living and met none of the assessment tool doors to qualify for the MI Choice Waiver.

The Appellant failed to establish by a preponderance of the evidence that she provided the MI Choice Waiver assessment team evidence in [redacted] that she met any of the seven doors of the assessment to qualify for the MI Choice Waiver.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, this Administrative Law Judge finds the Department properly determined that the Appellant did not meet the eligibility criteria for the MI Choice Waiver.

IT IS THEREFORE ORDERED that:

The Department's prior decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: __5/13/2011____

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.