STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

Docket No. 2011-4175 EDW

[redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted] appeared on his own behalf. [redacted] appeared as a witness for the Appellant.

[redacted], appeared on behalf of [redacted], the Department's MI Choice program waiver agency (hereafter, Department). [redacted], and [redacted], appeared as witnesses for the Department.

ISSUE

Did the Waiver Agency properly terminate participation in the MI Choice Waiver program following eligibility review?

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 Appellant is [redacted] and has been a participant in MI Choice Waiver Services since [redacted]. (Appellant Testimony)

2. The Appellant has multiple diagnoses including stroke/CVA, hypertension, and depression. (Exhibit 1, pages 18-19)

3. When the Appellant initially qualified for MI Choice Waiver services in [redacted], he was served by a different MI Choice Waiver agency. (Appellant and Medical Services Supervisor Testimony)

4. In [redacted], the Appellant's MI Choice Waiver services case was transferred to the [redacted]. (Medical Services Supervisor Testimony)

5. On [redacted], the waiver agency completed a re-assessment with the Appellant. (Exhibit 1, pages 12-27)

6. On [redacted], the waiver agency also completed a Michigan Medicaid Nursing Facility Level of Care Determination. (Exhibit 1, pages 8-11)

7. The Appellant did not meet the functional/medical eligibility criteria for Medicaid nursing facility level of care. (Exhibit 1, page 8)

8. On [redacted], the waiver agency issued notice to the Appellant indicating his MI Choice Waiver services would terminate. (Exhibit 1, page 3)

9. The Appellant requested a formal, administrative hearing on [redacted]. (Exhibit 1, page 36)

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, in this case the [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* or LOC). The LOC 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 Level of Care 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 Department 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

The Appellant reported that he was independent with bed mobility, transfers, toileting and eating at the time of the [redacted] re-assessment. (Exhibit 1, pages 9-10 and 23-24) The Appellant did not dispute his independence with these activities. The only trouble with activities of daily living the Appellant discussed in his testimony was increased difficulty with bathing, increased weakness walking, and having more falls. However, these are not

activities of daily living considered under Door 1. Accordingly, the Appellant did not score at least six (6) points to qualify through Door 1.

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."

No evidence was presented indicating the Appellant has severely impaired decision making or that he has a memory problem. The Appellant can make himself understood. The evidence presented is uncontested that the Appellant did not qualify under Door 2.

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.

No evidence was presented indicating the Appellant had any physician's visit exams or order changes within the 14 day period that would have allowed him to meet either of the criteria listed for Door 3 at the time of the re-assessment.

Door 4
Treatments and Conditions

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories above 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 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

No evidence was presented indicating the Appellant had met any of the criteria listed for Door 4 at the time of the re-assessment. Accordingly, the Appellant did not qualify under Door 4.

Door 5
Skilled Rehabilitation Therapies

Scoring Door 5: The applicant must have 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.

No evidence was presented indicating the Appellant received any skilled rehabilitation therapies within 7 days of the [redacted] reassessment. The Appellant explained that by [redacted], he had used up the therapy visits covered by his insurance. Accordingly, the Appellant did not 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.

No evidence was presented indicating the Appellant had any delusions, hallucinations, or any of the specified behaviors. Accordingly, the Appellant did not qualify under Door 6.

Door 7
Service Dependency

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

The assessment provides that the applicant could qualify under Door 7 if he is currently (and has been a participant for at least one (1) 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.

It is uncontested that the Appellant has been a participant for over one year. However, it is also uncontested that the only MI Choice Waiver services he is currently receiving, housekeeping, would be available to him from other resources. Accordingly, he could not meet the criteria to remain eligible through Door 7.

The Appellant asserted that he needs to remain on the MI Choice Waiver program to avoid having a spend down for his Medicaid coverage. He explained that his financial resources are limited and he would not be able to meet his spend down in order to qualify for Medicaid insurance coverage. While this is a valid concern, this ALJ is bound by the policy requiring MI Choice Waiver program participants to meet the Medicaid nursing facility level of care criteria. Based on the information at the time of the [redacted] re-assessment, the Appellant did not meet the Medicaid nursing facility level of care criteria. Accordingly, the Waiver Agency properly terminated the Appellant's MI Choice Waiver services.

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.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]
Docket No. 2011-4175 EDW
Decision and Order

cc: [redacted]

Date Mailed: 1/13/2011

***** 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.