STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2012-63895 EDW
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted], Appellant's daughter, appeared and testified on Appellant's behalf. Appellant was also present during the hearing. [redacted] Program Manager, represented the Department of Community Health's Waiver Agency, the Macomb-Oakland Regional Center, Inc. ("Waiver Agency" or "MORC"). [redacted] a registered nurse/supports coordinator, also testified as a witness for MORC.

ISSUE

Did the Waiver Agency properly terminate Appellant's services through 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. Appellant is a [redacted] who has been diagnosed with diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled; arthritis; depression; and glaucoma. (Exhibit 2, page 1; Exhibit 4, pages 7-8).

2. MORC is a contract agent of the Michigan Department of Community Health (MDCH) and is responsible for waiver eligibility determinations and the provision of MI Choice waiver services.

3. Appellant had been enrolled in and receiving MI Choice waiver services

through MORC, including 5 hours a week of personal care services and 9 hours a week of homemaking services. (Exhibit 5, page 1; Testimony of [redacted]).

4. On [redacted] MORC staff completed a new Level of Care Determination (LOCD) and reassessment of Appellant's needs and services. (Exhibit 2, pages 1-8; Exhibit 4, pages 1-16).

5. Based on Appellant's reports and their own observations during that reassessment, the Waiver Agency's staff found that Appellant did not qualify for the waiver program and her services should be terminated. (Exhibit 2, page 8; Exhibit 4, pages 15-16).

6. On [redacted] MORC sent Appellant a notice that it was terminating her personal care and homemaking services through the waiver program. The effective date of the termination was identified as [redacted]. (Exhibit 1, page 1).

7. On [redacted], the Department received a Request for Hearing regarding the termination of services in this case. (Exhibit 5, page 1).

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.

Appellant is claiming 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 Services to the Michigan Department of Community Health (Department). Regional agencies, in this case MORC, 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).]

Types of services that may be offered include:

> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> - Case management services.
> - Homemaker services.
> - Home health aide services.
> - Personal care services.
> - Adult day health services
> - Habilitation services.
> - Respite care services.
> - 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.
>
> Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization. [42 CFR 440.180(b).]

In this case, MORC terminated Appellant's personal case and homemaker services after finding that she no longer qualified for the waiver program. Appellant's representative disputes both those terminations and argues that she still needs the program's services. For the reasons discussed below, this Administrative Law Judge finds that the Waiver Agency's actions should be sustained.

With respect to the waiver program, federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria. Nursing facility residents must also meet Pre-Admission Screening/Annual Resident Review requirements.

The Medicaid Provider Manual, Nursing Facilities Coverages Section, [redacted] 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.

Here, MORC decided to deny Appellant's services after finding that she did not meet the medical criteria for the waiver program. With respect to functional eligibility for the waiver program, the Medicaid Provider Manual (MPM) provides:

> **2.2 FUNCTIONAL ELIGIBILITY**
>
> The MI Choice waiver agency must verify applicant appropriateness for services by completing the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) within 14 calendar days after the date of the participant's enrollment. (Refer to the Directory Appendix for website information.) The LOCD is discussed in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter. Additional information can be found in the Nursing Facility Coverages Chapter and is applicable to MI Choice applicants and participants.
>
> The applicant must also demonstrate a continuing need for and use of at least one covered MI Choice service. This need is originally established through the Initial Assessment using the process outlined in the Need For MI Choice Services subsection of this chapter.
>
> **2.2.A. MICHIGAN MEDICAI D NURSING FACILITY LEVEL OF CARE DETERMINATION**
>
> MI Choice applicants are evaluated for functional eligibility via the Michigan Medicaid Nursing Facility Level of Care Determination. The LOCD is available online through Michigan's Single Sign-on System. (Refer to the Directory Appendix for website information.)
>
> Applicants must qualify for functional eligibility through one of seven doors. These doors are:
>
> - Door 1: Activities of Daily Living Dependency
> - Door 2: Cognitive Performance
> - Door 3: Physician Involvement
> - Door 4: Treatments and Conditions

- Door 5: Skilled Rehabilitation Therapies
- Door 6: Behavioral Challenges
- Door 7: Service Dependency

The LOCD must be completed in person by a health care professional (physician, registered nurse (RN), licensed practical nurse (LPN), licensed social worker (BSW or MSW), or a physician assistant) or be completed by staff that have direct oversight by a health care professional.

The online version of the LOCD must be completed within 14 calendar days after the date of enrollment in MI Choice for the following:

- All new Medicaid-eligible enrollees

- Non-emergency transfers of Medicaid-eligible participants from their current MI Choice waiver agency to another MI Choice waiver agency

- Non-emergency transfers of Medicaid-eligible residents from a nursing facility that is undergoing a voluntary program closure and who are enrolling in MI Choice

Annual online LOCDs are not required, however, subsequent redeterminations, progress notes, or participant monitoring notes must demonstrate that the participant continues to meet the level of care criteria on a continuing basis. If waiver agency staff determines that the participant no longer meets the functional level of care criteria for participation (e.g., demonstrates a significant change in condition), another face-to-face online version of the LOCD must be conducted reflecting the change in functional status. This subsequent redetermination must be noted in the case record and signed by the individual conducting the determination.

> Copies of the LOCD for participants must be retained by the waiver agency for a minimum period of six years. This information is also retained in the MDCH LOCD database for six years. [MPM, MI Choice Waiver Section, July 1, 2012, pages 1-2.]

Regarding Door 1, the LOCD tool states:

> **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 [Exhibit 2, page 3.]

Regarding Door 2, the LOCD tool states:

> **Door 2**
> **Cognitive Performance**
>
> **Scoring Door 2**: The applicant must score under one of the following three options to qualify under Door 2.
>
> 2. "Severely Impaired" in Decision Making.
>
> 3. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
>
> 4. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood." [Exhibit 2, page 4.]

Regarding Door 3, the LOCD tool states:

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 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. [Exhibit 2, page 5.]

Regarding Door 4, the LOCD tool states:

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.

A. Stage 3-4 pressure sores
B. Intravenous or parenteral feedings
C. Intravenous medications
D. End-stage care
E. Daily tracheotomy 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 [Exhibit 2, page 5.]

Regarding Door 5, the LOCD tool states:

Door 5
Skilled Rehabilitation Therapies

Scoring Door 5: The applicant must have required at least 45 minutes of active [Speech Therapy], [Occupational Therapy] or [Physical Therapy] (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5 [Exhibit 2, page 6.]

Regarding Door 6, the LOCD tool states:

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. [Exhibit 2, page 7.]

Regarding Door 7, the LOCD tool states:

Door 7
Service Dependency

> **Scoring Door 7:** The applicant must be a current participant and demonstrate service dependency to qualify under Door 7. [Exhibit 2, page 7.]

Here, the Waiver Agency initially determined that Appellant did not pass through any of the 7 Doors and was therefore ineligible for the program.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in terminating her services. Given Appellant's answers during the LOCD and her representative's testimony during the hearing, it is clear that the Waiver Agency's decision should be sustained.

With respect to Door 1, Appellant's representative concedes that Appellant is independent with respect to bed mobility and eating, as found by MORC, but also claims that Appellant requires significant physical assistance with transferring and toileting. However, [redacted]r testified that she observed Appellant transferring and this Administrative Law Judge finds her credible on that issue. Moreover, while Appellant's representative now states that Appellant requires assistance with toileting, she also acknowledges that Appellant did not inform MORC of such a need during the reassessment. According to Appellant's representative, Appellant was too embarrassed to report her toileting needs. Whatever the reason, Appellant did not identify such a need and the Waiver Agency is justified in relying on what it is told. Given what it was told and what Appellant demonstrated, Appellant therefore does not meet the criteria for Door 1.

Similarly, while Appellant has medical problems, none of her conditions meet the criteria for passing through Doors 2, 4, or 6. Moreover, the medical treatment Appellant receives does not reach the levels required by Doors 3, 4, or 6.

With respect to Door 7, the Waiver Agency first noted that Appellant's needs could be met through her natural supports and other state programs, particularly the Adult Home Help program. Appellant was then referred to the Department of Human Services (DHS) so that she could apply for home help.

In response, Appellant's representative testified that Appellant has been in the same program for 12 years, is comfortable with that program, and does not want to change. However, the Waiver Agency is required by policy to routinely reassess its clients and it cannot authorize services when someone is not eligible.

Appellant's representative also testified that Appellant is a depressed, old lady who does not want to switch programs. However, this Administrative Law Judge does not have equitable jurisdiction and, like the Waiver Agency, is required to follow the applicable policy.

Appellant's representative further argues that Appellant's medical conditions have worsened since the reassessment. However, this Administrative Law Judge is limited to reviewing the Waiver Agency's decision in light of the information available at the time it made its decision. To the extent that Appellant's situation has changed or she has new information to provide, she can always reapply to the program.

For the reasons discussed above, this Administrative Law Judge finds that Appellant has failed to meet her burden of proof in this case and the decision to terminate services should be sustained.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/11/2012

***** 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.