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. 2012-74017 EDW
[redacted]
Case No. [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]. Appellant [redacted] appeared and testified on her own behalf. Appellant's granddaughter, [redacted] also testified for the Appellant.

[redacted] LBSW, Waiver Services Manager, Region II Area Agency on Aging, appeared and testified on behalf of the Department's Waiver Agency. [redacted], RN, Quality Management Supervisor, Region II Area Agency on Aging, also testified on behalf of the Waiver Agency.

ISSUE

Did the Department's Waiver Agency properly terminate Appellant's MI Choice Waiver 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. The Appellant is an [redacted], DOB [redacted] who was enrolled in the MI Choice Waiver Program. She had been receiving Medicaid covered services of personal care, mileage, and a PERS. (Exhibits D-G and testimony).

2. The Department contracts with the Waiver Agency to provide MI Choice Waiver services to eligible beneficiaries.

3. The Appellant lives by herself in [redacted] a senior apartment complex. (Exhibits A, E-G).

4. On [redacted], RN, Quality Management Supervisor, and [redacted] RN, Deputy Director, met with Appellant to do a Nursing Facility Level of Care Determination (NF LOC) to determine Appellant's continued eligibility for the MI Choice Waiver Program. A Nursing Facility Level of Care Determination (NFLOC) was completed and it was determined that Appellant did not qualify through any of the seven doors. The Waiver Agency determined that Appellant's needs could be met through Care Management grant services for homemaking and home delivered meals. (Exhibits A, B, D, G and testimony).

5. On [redacted] the waiver agency sent an Advance Action Notice to the Appellant notifying her of a termination of MI Choice Waiver services including her personal care, mileage and PERS. (Exhibits B, G and testimony).

6. On [redacted] MAHS received the Appellant's request for an Administrative Hearing. (Exhibit 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.

This Appellant was receiving 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 (CMS, formerly HCFA) to the Michigan Department of Community Health (Department). Regional agencies 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)*].

The policy regarding enrollment in the MI Choice Waiver program is contained in the *Medicaid Provider Manual, MI Choice Waiver*, October 1, 2012, which provides in part:

SECTION 1 – GENERAL INFORMATION

MI Choice is a waiver program operated by the Michigan Department of Community Health (MDCH) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria that supports required long-term care (as opposed to rehabilitative or limited term stay) provided in a nursing facility. The waiver is approved by the Centers for Medicare and Medicaid Service (CMS) under section 1915(c) of the Social Security Act. MDCH carries out its waiver obligations through a network of enrolled providers that operate as organized health care delivery systems (OHCDS). These entities are commonly referred to as waiver agencies. MDCH and its waiver agencies must abide by the terms and conditions set forth in the waiver.

MI Choice services are available to qualified participants throughout the state and all provisions of the program are available to each qualified participant unless otherwise noted in this policy and approved by CMS. (p. 1).

* * *

SECTION 2 - ELIGIBILITY

The MI Choice program is available to persons 18 years of age or older who meet each of three eligibility criteria:

- An applicant must establish his/her financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.

- The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).

- It must be established that the applicant needs at least one waiver service and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met in order to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program. (p. 1).

* * *

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 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. (p. 1).

* * *

2.2.A. MICHIGAN MEDICAID 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 fourteen (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. (pp. 1-2).

* * *

2.3.B. REASSESSMENT OF PARTICIPANTS

Reassessments are conducted by either a properly licensed registered nurse or a social worker, whichever is most appropriate to address the circumstances of the participant. A team approach that includes both disciplines is encouraged whenever feasible or necessary. Reassessments are done in person with the participant at the participant's home. (p. 4).

The Waiver Agency provided evidence that on [redacted] [redacted] RN, Quality Management Supervisor, and [redacted] RN, Deputy Director, met with Appellant to do a Nursing Facility Level of Care Determination (NFLOC) to determine Appellant's continued eligibility for the MI Choice Waiver Program. A Nursing Facility Level of Care Determination (NFLOC) was completed and it was determined that Appellant did not qualify through any of the seven doors. The Waiver Agency determined that Appellant's needs could be met through Care Management grant services for homemaking and home delivered meals.

[redacted] stated they went to Appellant's residence to do the reassessment, because they thought she might not be medically eligible for the MI Choice Waiver program. [redacted] stated they determined that Appellant did not qualify for medical eligibility through any of the seven doors. Appellant was found to be independent in her activities of daily living. Appellant did not demonstrate any problems with her memory. [redacted]

[redacted] stated Appellant was able to organize her daily routine and make safe decisions. She was able to make herself understood. [redacted] determined Appellant had no physician visits or order changes within the past 14 days. Appellant was not on daily oxygen or involved in any skilled rehabilitation therapies. Appellant did not report or display any challenging behaviors within the past 7 days. [redacted] stated the Appellant's needs for homemaking could be met through the Care Management program. (See also Exhibits A, B & G).

[redacted] stated while they were at the Appellant's apartment for the assessment, she witnessed the Appellant get up out of her recliner, push the recliner foot rest completely down with her foot, and go into the kitchen unassisted to retrieve a prescription bottle. She noted Appellant's gait was steady. [redacted] also stated Appellant did have an ER visit, but such a visit does not trigger eligibility through Door 3. (Also see Exhibit G).

Appellant testified she can only walk a little. She goes to [redacted] to get shots in her spine. She stated her back is real bad and they wanted to operate on it and put some wires in her back. She said she did not want to have the operation because she might end up in a wheelchair the rest of her life. Appellant said she doesn't do any cleaning or cooking. She stated she can't do anything.

The Appellant's granddaughter testified she was concerned for her grandmother. She stated Appellant has been on the program for eight years and her health has declined over that time. The granddaughter stated the family members are not able to make daily checks on the Appellant. She stated the girls that care for the Appellant are wonderful, and the Appellant needs to have this daily physical interaction with her care givers. The granddaughter acknowledged that her mother does medication set-ups for her grandmother. She also stated that her grandmother has a bad memory, she forgets everything.

The Appellant bears the burden of proving, by a preponderance of evidence, that the waiver agency did not properly terminate her MI Choice Waiver services. A preponderance of the material and credible evidence establishes that the MI Choice Waiver agency acted in accordance with the policy contained in the Medicaid Provider Manual, and its actions were proper when it terminated the Appellant's MI Choice program services. Therefore, the Appellant has failed to prove that the waiver agency's actions were not proper when it terminated the Appellant's MI Choice program services.

Based upon the reassessment performed by the waiver agent on [redacted] the Appellant was no longer medically eligible for the MI Choice program. Therefore, the Waiver Agency acted properly to terminate the Appellant from the program. The Waiver Agency is not simply dropping the Appellant, rather it indicated it would keep her on the Care Management grant services for homemaking and home delivered meals. Appellant will also be checked on monthly and receive quarterly reassessments. In the event that she again becomes medically eligible, Appellant can then be re-enrolled in the MI Choice Waiver program.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/23/2012

***** 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.