

Community Health (MDCH) and is responsible for waiver eligibility determinations and the provision of [REDACTED].

5. On [REDACTED] Appellant's Supports Coordinator, met with Appellant to do a [REDACTED] to determine Appellant's continued eligibility for the [REDACTED]. [REDACTED] found the Appellant did not meet the medical eligibility for the [REDACTED] (Exhibits 1-3 & 6 and testimony).
6. On [REDACTED], the Waiver Agency gave Appellant an advance action notice terminating her homemaker and transportation services, along with a request for hearing, and explained her right to appeal the decision. (Exhibits 1, 3 & 6).
7. On [REDACTED] sent Appellant an "Adequate Action Notice" indicating that they had reviewed her long term care needs and had determined that she no longer qualified for [REDACTED] based on the [REDACTED] ([REDACTED]) and that her [REDACTED] services would be terminated within [REDACTED] days. Appellant was notified of her rights to a Medicaid Fair Hearing. (Exhibit 4).
8. On [REDACTED] MAHS received the Appellant's request for an administrative hearing. (Exhibit 7).

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 the Senior Alliance-1C, 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)

Home and community based services means services not otherwise furnished under the State’s Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter. 42 CFR 440.180(a).

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).

The *Medicaid Provider Manual, MI Choice Waiver*, April 1, 2012, 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 [REDACTED] provided evidence that on [REDACTED] Appellant was reassessed and it was determined she was no longer eligible for the [REDACTED] program. [REDACTED] submitted the following exhibits on behalf of the [REDACTED]

Exhibit 1, the 1 page Hearing Summary

Exhibit 2, a 10 page Freedom of Choice form and Nursing Facility Level of Care Determination

Exhibit 3, a 1 page Advance Action Notice/Termination of Services form

Exhibit 4, a 1 page MPRO Adequate Action Notice

Exhibit 5, a 2 page copy of Attachment K of the Waiver Agency's contract with the Department

Exhibit 6, a 16 page WISP – Participant Assessment Report

Exhibit 7, Appellant's Request for Hearing

Docket No. 2012-37487 EDW
Decision and Order

██████████ testified that ██████████, ██████████, Appellant's Supports Coordinator, met with Appellant to do a Nursing Facility Level of Care Determination ██████████ to determine Appellant's continued eligibility for the ██████████. ██████████ stated ██████████ found the Appellant did not meet the medical eligibility for the ██████████. (Exhibits 1-3 & 6). ██████████ stated ██████████ further determined that the Appellant was independent in her activities of daily living and did not meet the service dependence requirement in order to continue her enrollment in the ██████████.

██████████ stated the Appellant then appealed the decision by the ██████████. ██████████ reviewed the ██████████ decision and on ██████████ sent Appellant written notification that the Senior Alliance's decision was upheld and that her MI choice Waiver services were going to be terminated in ██████████. ██████████ stated the Appellant was then disenrolled from the program.

Appellant ██████████ testified she needed her homemaker and transportation services. Appellant acknowledged that ██████████ came out and did an evaluation at her apartment. Appellant indicated that she was told over the phone that she did not qualify for the ██████████. She did not think that ██████████ had given her the termination notice in person.

Appellant acknowledged that she appealed the decision to terminate her services to ██████████. Again she did not believe that she got ██████████'s notice in the mail. Appellant indicated people are taking her mail out of her mailbox and she does not get all of her mail. Appellant stated she has had six heart surgeries and she takes nitroglycerin every night. Appellant stated she needs transportation in case she would have to go to the hospital.

Weighing the evidence in this case, the Waiver Agency provided a preponderance of evidence to show that the Appellant was not eligible for the ██████████ at the time they did the reassessment on ██████████. The Appellant did not prove by a preponderance of evidence that she required a Nursing Facility Level of Care and that she continued to meet the ██████████ eligibility criteria. ██████████ established that the Appellant did not meet the eligibility requirements for the program. The reassessment showed that she did not meet the medical eligibility or the service dependence required to continue in the waiver program.

Accordingly, based upon the reassessment performed by the ██████████ on ██████████, the Appellant was no longer eligible for ██████████. ██████████ acted properly finding that she was ineligible for the ██████████ and in terminating her services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly determined the Appellant was not eligible for the [REDACTED].

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

William D Bond

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: ___ 4-16-12 _____

***** 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.