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) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 2012-68051 EDW
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]. [redacted], Appellant's [redacted] appeared and testified on Appellant's behalf. Appellant did not appear for the hearing as she was recently hospitalized. [redacted] indicated that she wished to go forward with the hearing on her [redacted] behalf.

[redacted], LLMSW, CCD Support Coordinator, The Senior Alliance 1-C, represented the Department's Waiver Agency. (Waiver Agency or Senior Alliance). Edtrineise Page, Waiver Director, also appeared but did not testify.

ISSUE

Did the Waiver Agency properly determine that Appellant was no longer eligible for 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 Appellant is an [redacted] year old Medicaid beneficiary, born [redacted] who has been enrolled in the MI Choice Waiver Program. (Exhibit A, p 3; Testimony).

2. The Waiver Agency 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. (Exhibit A, pp 1-3).

3. The Appellant is diagnosed with emphysema, chronic obstructive pulmonary disease, arthritis, osteoporosis, diabetes mellitus, hypothyroidism, low tension glaucoma, and high cholesterol. Appellant has a history of pulmonary embolism and recurrent UTI's. Appellant uses oxygen at night to treat her COPD. (Exhibit A, pp 9-10).

4. The Appellant lives alone in an apartment. Appellant's [redacted] and her [redacted] alternate months that they assist their [redacted] Appellant's [redacted] help with shopping and transportation (Exhibit A, p 6).

5. On [redacted], a reassessment of the Appellant was done by the Waiver Agency to determine continued eligibility for the MI Choice Waiver Program. (Exhibit A).

6. On [redacted], the Waiver Agency sent Appellant an Advance Action Notice informing Appellant that it determined she was no longer eligible for the MI Choice Waiver Program and advised her that services would be terminated effective August 1, 2012. (Exhibit A, p 29).

7. On [redacted], the Michigan Administrative Hearing System 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 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 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)*

> 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).

On [redacted], the Department issued MI Choice Operations Advisory Letter #26. The letter states in part:

> **MI CHOICE CONTRACT REQUIREMENTS**
>
> The MI Choice contract requires waiver agents to seek all other forms of payment before authorizing MI Choice services (Attachment K, pp. 43-44). The HHS program is another form of payment for home and community based services, and therefore the participant and supports coordinators must fully consider this option **before** MI choice enrollment. MI Choice participants cannot receive services from both the HHS program and MI Choice, as this is a duplication of Medicaid services. (Attachment K, pp. 25-26).

The Michigan Department of Community Health, Medical Services Administration issued bulletin number MSA 11-27 on [redacted], effective [redacted], for the purpose of adding a MI Choice Policy Chapter to the Medicaid Provider Manual. This new policy chapter 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.

* * *

2.2.B. FREEDOM OF CHOICE

Applicants or their legal representatives must be given information regarding all long-term care service options for which they qualify through the NF LOCD, including MI Choice, Nursing Facility and the Program of All-Inclusive Care for the Elderly (PACE). That a participant might qualify for multiple programs does not mean they can be served by all or a combination thereof for which they qualify. Nursing facility, PACE, MI Choice, and Adult Home Help services may not be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options via the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the individual (or his/her legal representative) seeking services and is to be maintained in the participant case record.

* * *

2.3. NEED FOR MI CHOICE SERVICES

In addition to meeting financial and functional eligibility requirements and to be enrolled in the program, MI Choice applicants must demonstrate the need for a minimum of one covered service as determined through an in-person assessment and the person-centered planning process.

Note: Supports coordination is considered an administrative activity in MI Choice and does not constitute a qualifying requisite service. Similarly, informal support services do not fulfill the requirement for service need.

An applicant cannot be enrolled in MI Choice if his/her service and support needs can be fully met through the intervention of State Plan or other available services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications. *Emphasis added*.

* * *

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.
>
> *Medicaid Provider Manual, MI Choice Waiver [redacted], pp 1-5*

Effective [redacted], 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, [redacted]005, 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 [redacted].

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

Appellant reported no limitations with activities of daily living. As such, the Appellant did not qualify under Door 1. (Exhibit A, pp 19-20).

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."

Appellant does have a memory problem, but she is independent in cognitive skills for daily decision-making and is able to make herself understood. As such, she did not qualify under door 2. (Exhibit A, p 21).

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.

Appellant reported two physician's visits within the [redacted]-day period leading up to the LOC Determination but no physician change orders. As such, Appellant did not qualify under Door 3. (Exhibit A, pp 22-23)

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 [redacted] 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 [redacted] days
G. Daily oxygen therapy
H. Daily insulin with two order changes in last [redacted] days
I. Peritoneal or hemodialysis

Appellant does require daily oxygen use and she has a continuing need for the oxygen because of her COPD. Accordingly, the Appellant did qualify under Door 4. (Exhibit A, p 23)

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 that Appellant has ever received speech, physical, or occupational therapy. Accordingly, 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 [redacted] 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 that Appellant had any delusions, hallucinations, or any of the specified behaviors within [redacted] days of the LOC Determination. Accordingly, 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 LOC Determination provides that Appellant could qualify under Door 7 if she 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.
>
> Here, Appellant has been in the MI Choice Program for more than one year and does require ongoing services to maintain current functional status, but the Waiver Agency argues that other community services, specifically the Care Management program, could meet Appellant's needs.

As indicated above, the MPM provides, "An applicant cannot be enrolled in MI Choice if his/her service and support needs can be fully met through the intervention of State Plan or other available services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications."

Appellant's [redacted] testified that Appellant still needs a PERS unit and that this service was discontinued when her [redacted] was transferred to the Care Management program. Appellant's [redacted] indicated that Appellant is prone to dizziness and that she falls all the time. Appellant's [redacted] indicated that Appellant has fallen three times in the past month and that she has fallen twice in the past where the PERS unit saved her life. Appellant's [redacted] testified that her [redacted] lives alone and does not have a cell phone that she can carry with her in case of a fall. Appellant's [redacted] also indicated that Appellant cannot afford a PERS unit on her own and no-one in the family is able to help her financially.

The Waiver Agency witness testified that when Appellant was transferred to the Care Management program, she provided Appellant with low cost options for a PERS unit. The lowest cost option was $[redacted] per month. The Waiver Agency witness also indicated that Appellant's Emergency Plan states that Appellant is capable of pressing her PERS unit *or calling 911 in case of emergency*. The Waiver Agency witness interpreted this portion of Appellant's emergency plan to mean that Appellant did not need a PERS unit because she could call 911. However, the evidence shows that Appellant lives alone and does not have a cell phone. As such, if she falls, which she has many times in the past, and is not near her house phone, she would not be able to call for help. The proper interpretation of Appellant's emergency plan is that Appellant could call 911 in an emergency where she was still on her feet, or she could use her PERS unit to summons assistance if she falls and cannot get to the phone.

The Waiver Agency witness also argued that Appellant did not qualify for the MI Choice Waiver Program because she was not dependent on the service because she could bathe herself. However, the Appellant qualified for the MI Choice Program through Door #4 because of her need for daily oxygen use, not through Door #1 because she needed help with activities of daily living. Clearly, Appellant is dependent on daily oxygen use because of her COPD.

Appellant did prove by a preponderance of the evidence that the Waiver Agency erred in finding that she was no longer eligible for the MI Choice Waiver Program. Appellant provided evidence to show that she needs a specific service provided only through the MI Choice Waiver program, specifically a PERS unit, and that her needs could not be met through the Care Management Program. Therefore, the Appellant is eligible for 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 Waiver Agency erred in determining that Appellant was not eligible for the MI Choice Waiver Program.

IT IS THEREFORE ORDERED that:

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

/s/

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

cc: [redacted]

Date Mailed: January 25, 2013

***** 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.