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

Moran, Joyce E.,

Appellant
_____/

Docket No. 2013-17250 EDW
Case No. 92974613

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 January 24, 2013. Appellant appeared and testified on her own behalf. Barbara Stoy, Contract Manager, represented the Department of Community Health's Waiver Agency, the Region II Area Agency on Aging ("Waiver Agency" or "AAA"). Claire Warner, registered nurse/clinical manager, and Mary Bonilla, social worker/supports coordinator, also testified as a witness for the Waiver Agency.

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 69 year-old Medicaid beneficiary who has been diagnosed with chronic obstructive pulmonary disease (COPD), peripheral vascular disease, arthritis, depression, diabetes mellitus, and hypertension. (Respondent's Exhibit D, pages 1, 7-8).

2. AAA 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 has been enrolled in and receiving MI Choice waiver services through AAA, including community living supports (CLS), a Pers lifeline unit, and lawn service. (Respondent's Exhibit A, page 1; Respondent's Exhibit D, page 15).

4. On December 3, 2012, Mary Bonilla and Rhonda Edwards from AAA completed a new Level of Care Determination (LOCD) and assessment of Appellant's needs and services. (Respondent's Exhibit F, pages 1-8; Testimony of Bonilla; Testimony of Appellant).

5. Based on Appellant's reports and the observations of its workers during that reassessment, AAA found that Appellant no longer qualified for the waiver program. (Respondent's Exhibit A, page 1; Testimony of Bonilla; Testimony of Warner).

6. On December 4, 2012, AAA sent Appellant written notice that it was terminating her CLS, Pers unit, and lawn service as she was no longer medically eligible for the waiver program. (Respondent's Exhibit A, page 1).

7. On December 13, 2012, the Department received a Request for Hearing regarding the termination of services in this case. (Petitioner's Exhibit 1, 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 AAA, 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. *See* 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).]

Moreover, 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, July 1, 2012, 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, AAA 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 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 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 Chapter, October 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 [Respondent's Exhibit F, page 2.]

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." [Respondent's Exhibit F, page 3.]

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. [Respondent's Exhibit F, page 4.]

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 [Respondent's Exhibit F, page 4.]

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 [Respondent's Exhibit F, page 5.]

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. [Respondent's Exhibit F, page 6.]

Regarding Door 7, the LOCD tool states:

Door 7
Service Dependency

Program participant for at least one year and requires ongoing services to maintain current functional status. [Respondent's Exhibit F, page 6.]

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

Given Appellant's answers during the LOCD and her testimony during the hearing, it is clear that the Waiver Agency's decision should be sustained. Appellant only seeks assistance with certain tasks, but none of that requested assistance relates to the tasks identified in Door 1. Similarly, while Appellant has medical problems, none of his 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. Appellant does use an oxygen machine at night, but she does not have the constant daily oxygen therapy required by the LOCD. Finally, with respect to Door 7, the Waiver Agency properly noted that the homemaking services Appellant does seek can be provided through its care management program and Appellant therefore does not have a service dependency.

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 services.

IT IS THEREFORE ORDERED that:

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

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

cc: Joyce E. Moran
Barbara Stoy
Mike Daeschlein
Brian Barrie
Sherri King
Elizabeth Aastad

Date Mailed: 3/8/2013

***** 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.