

**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:

██████████,

Appellant

_____ /

Docket No. 2013-40011 EDW
Case No. ██████████

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 ██████████. ██████████, Appellant's daughter, appeared and testified on Appellant's behalf. ██████████, Appellant's daughter and current caregiver, was also present as a witness for Appellant. ██████████, E/D Waiver Supervisor, represented the Department of Community Health's Waiver Agency, the ██████████. ("Waiver Agency" or "MORC"). ██████████, registered nurse/supports coordinator, also testified as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency proper 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 an ██████ year-old female who has been diagnosed with arthropathy, not otherwise specified; congestive heart failure; coronary heart disease; hypertension; arthritis; anxiety; and diabetes mellitus. (Respondent's Exhibit C, page 1; Respondent's Exhibit D, 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 has been enrolled in and receiving MI Choice waiver services through MORC. (Undisputed testimony during hearing).
4. Specifically, Appellant has been receiving 23 hours of services per week

through MORC. (Undisputed testimony during hearing).

5. The assistance is generally authorized for both personal care and homemaking tasks. However, the hours are also authorized through MORC's Self Determination (SD) program and, pursuant to that program, Appellant and her family decided how exactly how the hours are used. (Undisputed testimony during hearing).
6. Appellant's services were reassessed on ██████████ and, at that time, she was found to be eligible for the same amount of services as before. (Respondent's Exhibit D, pages 1-15).
7. At the time of the reassessment, Appellant's daughter ██████████ was her formal caregiver paid by MORC. (Respondent's Exhibit D, page 7).
8. Subsequently, Appellant and her family decided to make another daughter, ██████████, her formal caregiver. (Undisputed testimony during hearing).
9. While reviewing the paperwork regarding the switch in caregivers, MORC staff determined that Appellant's needs could be met via the State of Michigan's Home Help Services (HHS) program and, consequently, Appellant was not eligible for the Waiver Program. (Testimony of ██████████).
10. On ██████████, MORC sent Appellant an Advance Action Notice stating that her personal care and homemaker services were to be terminated due to a referral to the HHS program. (Petitioner's Exhibit 1, page 2).
11. The written advanced notice also provided that the termination would be effective ██████████, unless a request for fair hearing was received prior to that date. (Petitioner's Exhibit 1, page 2).
12. On ██████████, the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed by Appellant. (Petitioner's Exhibit 1, pages 1-3).
13. Given timing of the appeal, Appellant's services have been maintained at their current level while this appeal is pending. (Undisputed testimony during hearing).

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. 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).]

Here, as discussed above, the Waiver Agency found that Appellant was no longer eligible for services through the Waiver Program because her needs could be met through the Home Help Services (HHS) program administered as part of the State Plan by the Departments of Human Services (DHS) and Community Health (DCH).

With respect to the interaction between MI Choice services and other state services, including HHS, DCH issued MI Choice Operations Advisory Letter #26 on October 18, 2010. 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.]

Similarly, the applicable version of the State of Michigan's Medicaid Provider Manual (MPM) provides:

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 Services (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.

* * *

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 their 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 nursing facility 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 cannot 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 applicant (or their legal representative) seeking services and is to be maintained in the applicant's 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 their 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.

[MPM, April 1, 2013 version, MI Choice Waiver Chapter, pages 1-3 (italics added for emphasis).]

Regarding the specific MI Choice services at issue in this case, the MPM states:

4.1.B. HOMEMAKER

Homemaker services include the performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker when the individual regularly responsible for these activities, e.g., the participant or an informal supports provider, is temporarily absent or unable to manage the home and upkeep for himself or herself. Each provider of Homemaker services must observe and report

any change in the participant's condition or of the home environment to the supports coordinator.

4.1.C. PERSONAL CARE

Personal Care services encompass a range of assistance to enable program participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This may take the form of hands-on assistance (actually performing a task for the participant) or cueing to prompt the participant to perform a task. Personal Care services are provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law.

Services provided through the waiver differ in scope, nature, supervision arrangement, or provider type (including provider training and qualifications) from Personal Care services in the State Plan. The chief differences between waiver coverage and State Plan services are those services that relate to provider qualifications and training requirements, which are more stringent for personal care provided under the waiver than those provided under the State Plan.

Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. These services may also include assistance with more complex life activities. The service may include the preparation of meals but does not include the cost of the meals themselves. When specified in the plan of service, services may also include such housekeeping chores as bed making, dusting, and vacuuming that are incidental to the service furnished or that are essential to the health and welfare of the participant rather than the participant's family. Personal Care may be furnished outside the participant's home. [MPM, April 1, 2013 version, MI Choice Waiver Chapter, pages 9-10.]

Adult Services Manual 101 (11-1-2011) (hereinafter "ASM 101") and Adult Services Manual 120 (5-1-2012) (hereinafter "ASM 120") address the issues of what services are included in HHS and how such services are assessed. ASM 101 provides, in part,:

Home Help Payment Services

Home Help Services are non-specialized personal care service activities provided under the independent living

services program to persons who meet eligibility requirements.

Home Help Services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.

Home Help Services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, Intermediate Care Facility (ICF) for persons with developmental disabilities or institution for mental illness.

These activities must be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. **The medical professional does not prescribe or authorize personal care services.** Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)

- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Housework.

An individual must be assessed with at least one Activity of Daily Living (ADL) in order to be eligible to receive home help services.

[ASM 101, pages 1-3 of 4.]

Moreover, ASM 120 states:

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping
- Laundry
- Light Housework

* * *

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for Activities of Daily Living and Instrumental Activities of Daily Living.

* * *

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all instrumental activities of daily living except medication. The limits are as follows:

- Five hours/month for shopping.
- Six hours/month for light housework.
- Seven hours/month for laundry.
- 25 hours/month for meal preparation.

Proration of IADLs

If the client does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for each task. Assessed hours for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as home help services are **only** for the benefit of the client. [ASM 120, pages 2-4 of 5.]

Given the above policies, the Waiver Agency properly found that MI Choice services can no longer be approved in this case because Appellant's needs could be met by the HHS program. An applicant cannot be enrolled in MI Choice if her service and support needs can be fully met through the intervention of State Plan or other available services, such as the HHS program. Additionally, the HHS program is specifically identified as another form of payment for home and community based services, and the participant and supports coordinators must fully consider the HHS program before MI Choice enrollment as the MI Choice program is a payor of last resort.

Appellant only receives personal care and homemaking services through MORC, and both of those types of services are covered by HHS. Similarly, Appellant's representative only testified that Appellant needs assistance with tasks like bathing; toileting; dressing; and taking medications; and HHS includes assistance with those tasks.

Appellant's representative argues Appellant had been in the HHS program in the past, over ten years ago, and that it was Appellant's DHS caseworker who referred her to the MI Choice Waiver Program because the worker felt the Waiver Program would better meet Appellant's needs. Appellant's representative also argues that Appellant's needs have only increased since that time and it is difficult to see how the Waiver Agency now believes HHS can meet her needs. Appellant's representative could not identify any specific services Appellant needs that could not be provided through HHS, but did express concern that the hours of service through HHS would be less than the hours of care Appellant was receiving through the Waiver Program.

However, as described in the other policy, Appellant cannot be enrolled in MI Choice if her service and support needs can be fully met through the intervention of State Plan or other available services, such as HHS.

Here, Appellant did not prove by a preponderance of evidence that the Waiver Agency erred in terminating her services and referring Appellant to DHS-HHS. Appellant did not provide any sworn testimony or evidence to show that the Appellant needed a specific service provided only through the MI Choice Waiver program or that her needs could not be met through the HHS program. Moreover, the fact that Appellant was transferred to the MI Choice Waiver program from the HHS program in the past is irrelevant. The only relevant inquiry is whether the HHS program can meet Appellant's needs at the present time. Based on the evidence presented, it can.

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 Waiver Agency's decision to terminate Appellant's waiver services is **AFFIRMED**.

Steven Kibit

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

Date Signed: 7/2/2013

Date Mailed: 7/2/2013

[REDACTED]
cc:

[REDACTED]

[REDACTED]
Docket No. 2013-40011 EDW
Decision and Order

***** 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.