

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. 2013-43924 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. upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Attorney R ██████████ appeared on Appellant's behalf. ██████████, Appellant's daughter, appeared as a witness.

██████████, Program Manager, ██████████, ██████████, ██████████, ██████████, represented the Department's Waiver Agency. (Waiver Agency or MORC). ██████████, Supports Coordinator, appeared as a witness for the Waiver Agency.

ISSUE

Did the Waiver Agency properly close Appellant's case due to no response?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the commencement of the hearing, the parties stipulated that Appellant was found eligible for the MI Choice Waiver Program following his assessment in ██████████ and that Appellant's daughter was qualified to be his caregiver. (Testimony)
2. Appellant was assessed for the MI Choice Waiver Program on ██████████. (Exhibit A, pp 9-16; Testimony). As a result of the assessment, Appellant was found eligible for the Waiver Program through Door #1. (Exhibit A, pp 8-11)
3. 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, Testimony)

4. The Appellant is an █████ year-old Medicaid beneficiary, born █████, who is diagnosed with senile dementia, coronary heart disease, hypertension, peripheral vascular disease, stroke/CVA, transient ischemic attack, depression, and cancer. (Exhibit A, pp 23-24)
5. Appellant lives with his daughter in a single family home. Appellant's daughter is his primary caregiver and has a durable power of attorney for Appellant. Appellant also has two sons, but they are not in contact with Appellant and provide no support. (Exhibit A, p 20; Testimony).
6. Following Appellant's initial assessment, numerous calls were made between the Waiver Agency and Appellant's daughter to resolve the issue of whether Appellant's daughter could be the paid caregiver through the MI Choice Waiver Program. (Exhibit A, pp 3-8; Testimony).
7. On █████, the Waiver Agency sent Appellant's daughter an Adequate Action Notice informing her that Appellant's case was being closed due to no response from her. (Exhibit A, p 2).
8. On █████, the Michigan Administrative Hearing System received the Appellant's request for an administrative hearing. (Exhibit 2).

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 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 October 18, 2010, 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 July 1, 2011, effective August 1, 2011, 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.

* * *

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 Section
April 1, 2013, pp 1-5*

The Waiver Agency's Program Manager witness testified that following Appellant's assessment on ██████████ numerous phone calls were exchanged with Appellant's daughter to resolve the issue of whether Appellant's daughter could be paid directly by the Waiver Agency to be Appellant's caregiver. The Waiver Agency's Program Manager testified that they do not pay family members directly to be caregivers but that family members can be caregivers provided they work through a contracted agency. The Waiver Agency's Program Manager also testified that Appellant was not eligible to have a self-determination arrangement through which he could hire and pay his daughter to be his caregiver on his own because of his dementia. The Waiver Agency's Program Manager testified that Appellant's daughter was informed numerous times that she would have to be paid through an Agency if she wished to be Appellant's caregiver. The Waiver Agency's Program Manager indicated that the Waiver Agency sent Appellant's daughter a list of provider agencies but, when Appellant's daughter did not sign up with one by ██████████, the Waiver Agency sent Appellant's daughter an Adequate Action Notice informing her that Appellant's case was being closed due to no response.

The Waiver Agency's Social Worker testified that she was present for the assessment on ██████████, but that the majority of the assessment and follow-up was handled by the R.N., who no longer worked for the Waiver Agency.

Appellant's daughter testified that the first letter she received from the Waiver Agency indicated that the assessment was to be on the morning of the same day she received the letter. Appellant's daughter testified that she contacted the Waiver Agency's R.N., who confirmed that the meeting would still take place as scheduled the next day. Appellant's daughter testified that at the assessment on ██████████, she was told by the R.N. and the Social Worker that she could not be Appellant's caregiver and that Appellant would need to receive services through an agency. Appellant's daughter indicated that when she followed up with the Waiver Agency and the Department of Community Health to try to confirm this assertion, she learned that she could, in fact, be Appellant's caregiver, provided she worked through an Agency.

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Appellant's daughter testified that she was then sent a list of provider agencies and began researching them to see which would be the best fit. Appellant's daughter indicated that many of the agencies she talked to wanted to know how many hours of care per day Appellant had been approved for before they hired her, but that the Waiver Agency's R.N. was unwilling to give her this information. Appellant's daughter testified that she felt caught in the middle between the Waiver Agency and the provider agencies. Appellant's daughter testified that Appellant then went into the hospital from ██████████ through ██████████, which limited her ability to contact the provider agencies. Appellant's daughter testified that when she last spoke to the Waiver Agency's R.N. on ██████████, the R.N. ended the call abruptly and 5 days later she received the closing letter. Appellant's daughter indicated that at the time of that call, she was waiting for a hiring packet from one of the provider agencies.

Based on the evidence presented, the Waiver Agency was proper in closing Appellant's case. Appellant was found eligible for the program following an assessment on ██████████, but Appellant's daughter had not signed up to be a caregiver with a provider agency by ██████████, a period of over 2 months. Appellant's daughter attempts to blame the Waiver Agency for the delay by pointing out that the Waiver Agency initially gave her incorrect information regarding whether she could be Appellant's caregiver, but that misunderstanding was cleared up by ██████████, 6 days following the assessment. (Exhibit A, p 7). Appellant's daughter also seeks to excuse the delay by pointing out that Appellant was in the hospital, but that was only for a period of 11 days out of the over two months Appellant's daughter had to sign up with an agency. Finally, Appellant's daughter seeks to blame the delay on the fact that the Waiver Agency would not tell her how many hours Appellant was entitled to, but there is no way the Waiver Agency could provide that information until a caregiver was in place and a plan of care developed. Given that the Waiver Agency could not begin to provide services to Appellant because of Appellant's daughter's inaction, it had no other choice than to close Appellant's case.

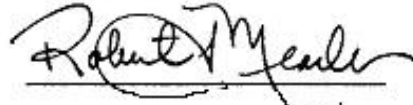
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DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly closed Appellant's case for no response.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.



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

[REDACTED]
cc: [REDACTED]

Date Signed: June 27, 2013

Date Mailed: June 27, 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.