

**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:

Docket No. 2014-35541 EDW

██████████

██████████

██████████

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 ██████████. Appellant appeared and testified on his own behalf.

██████████, R.N., Quality and Training Manager, appeared and testified on behalf of the Department of Community Health's (Department) Waiver Agency, ██████████ ██████████, R.N., Support Coordinator with ██████████ ██████████ also testified on behalf of the Department of Community Health's (Department) Waiver Agency.

ISSUE

Did the Department's Waiver Agency properly deny an increase in the Appellant's MI Choice Waiver services?

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 a ██████-year-old, ██████████), who is enrolled in the MI Choice Waiver Program. (Exhibit A, p. 1 and testimony).
2. The Department contracts with the Waiver Agency to provide MI Choice Waiver services to eligible beneficiaries. (Testimony).

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3. On [REDACTED], Appellant activated his PERS button at [REDACTED] due to a fall. [REDACTED], R.N., Support Coordinator spoke with the Appellant. Appellant stated to [REDACTED] that he wanted another [REDACTED] of caregiving because they don't have enough time to cook for him and clean the house. (Exhibit A, p. 2).
4. On [REDACTED], an Adequate Action Notice was sent to the Appellant denying his request for an increase in hours of Comprehensive Community Supports through the MI Choice Waiver Program, as the Appellant was authorized [REDACTED] hours per week through [REDACTED] which were determined to be sufficient to meet his needs. (The notice should have said [REDACTED] hours not [REDACTED] hours). (Exhibit A, pp. 1, 23, 24 and testimony).
5. On [REDACTED], [REDACTED] met with Appellant to reassess his current needs for services in the MI Choice Waiver Program. She found showed no significant change in the Appellant's physical condition, and determined that his MI Choice Waiver Services should remain at [REDACTED] hours per week to provide the hands-on care needed by the Appellant. (Exhibit A, pp. 1, 3-22 and testimony).
6. On [REDACTED], MAHS 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 requested 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 (CMS, 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

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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)].

The policy regarding enrollment in the MI Choice Waiver program is contained in the *Medicaid Provider Manual, MI Choice Waiver*, April 1, 2014, which 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.

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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.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

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- 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].

* * *

SECTION 4 – SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the current assessment;
 - detailed in the plan of service; and
 - provided in accordance with the provisions of the approved waiver.
- [p. 9].

* * *

4.1 COVERED WAIVER SERVICES

In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections. [p. 9].

* * *

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. (p. 9).

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. [p. 10].

* * *

4.1.I. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) services facilitate an individual's independence and promote reasonable participation in the community. Services can be provided in the participant's residence or in a community setting to meet support and service needs.

CLS may include assisting, reminding, cueing, observing, guiding, or training with meal preparation, laundry, household care and maintenance, shopping for food and other necessities, and activities of daily living such as bathing, eating, dressing, or personal hygiene. It may provide assistance with such activities as money management, non-medical care (not requiring nurse or physician intervention), social participation, relationship maintenance and building community connections to reduce personal isolation, non-medical transportation from the participant's residence to community activities, participation in regular community activities incidental to meeting the individual's community living preferences, attendance at medical appointments, and acquiring or procuring goods and services necessary for home and community living.

CLS staff may provide other assistance necessary to preserve the health and safety of the individual so they may reside and be supported in the most integrated independent community setting.

CLS services cannot be authorized in circumstances where there would be a duplication of services available elsewhere or under the State Plan. CLS services may not be authorized in lieu of, as a duplication of, or as a supplement to similar authorized waiver services. The distinction must be apparent by unique hours and units in the individual's plan of service. Tasks that address personal care needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care service in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.

When transportation incidental to the provision of CLS is included, it must not also be authorized as a separate waiver service. Transportation to medical appointments is covered by Medicaid through the State Plan.

Community Living Supports do not include the cost associated with room and board. [pp. 12-13].

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The Waiver Agency provided evidence that the Appellant was asking for one additional hour of services in the afternoons because he said the aides were not getting the work done and there wasn't time to cook his meal. [REDACTED] R.N., the Quality and Training Manager for the [REDACTED] stated their Supports Coordinator [REDACTED] and her Manager [REDACTED], Chief of the Community Care Department looked into this matter and determined that it wasn't a question of there not being enough time for the aides to get the work done, rather they just weren't doing their assigned tasks, and there was a dispute between the aides on who was supposed to complete which tasks. [REDACTED] determined that they needed to find a different vendor to provide care for the Appellant.

[REDACTED] stated their Contract Specialist, [REDACTED], has talked to [REDACTED] different vendors, and has been turned down, because of the Appellant's requested hours, [REDACTED], and [REDACTED] also stated the Appellant has a history with some of the agencies, he has requested that no [REDACTED]-[REDACTED] be sent as aides, and he has been sexually inappropriate with aides in the past. [REDACTED] said the Appellant is currently authorized [REDACTED] hours per week for care services and an additional [REDACTED] hours on [REDACTED], for the aides to run errands. [REDACTED] concluded by stating that the [REDACTED] has authorized a one-time deep cleaning of the Appellant home when the new vendor is in place to allow them to catch up on the Appellant's housekeeping.

[REDACTED], R.N., Support Coordinator for [REDACTED] testified that on [REDACTED] Appellant activated his PERS button at [REDACTED] due to a fall, and she was notified of this by the vendor. [REDACTED] stated she called the Appellant to make sure he was all right. During the call Appellant told [REDACTED] he wanted another hour of caregiving because the aides didn't have enough time to cook for him and clean the house. [REDACTED] stated after several visits with the Appellant and the home care aides by her and their Manager, it was determined that the Appellant had enough service hours to meet his needs, but the caregivers were failing to complete their assigned work. [REDACTED] stated when they do their assessment they utilize a worksheet that allows them to determine how many hours of caregiving an individual will need to meet their care needs. She said when she utilized the worksheet for the Appellant it came up with [REDACTED] hours. [REDACTED] said in her opinion the [REDACTED] hours of services authorized were sufficient to meet the Appellant's care needs.

[REDACTED] stated on [REDACTED] she met with the Appellant for a [REDACTED]-day reassessment for services in the MI Choice Waiver Program. [REDACTED] said the reassessment showed no significant change in the Appellant's physical condition and this reaffirmed that his MI Choice Waiver Services should remain at the [REDACTED] hours per week previously authorized in order to meet his current care needs.

Appellant testified that different people do things differently and can take longer to do certain tasks. He indicated that his aides with [REDACTED] did not get to work immediately when they get to his house. They will sit down, look at TV, and talk to him about their problems. He said the afternoon shift does their work properly, but

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sometimes there is a problem with getting his briefs on right. Appellant said he did not think [REDACTED] was the best company. He reluctantly acknowledged that the aides might be able to get their work done on time if they got right to work when they arrived, but said it might be tough. Appellant also said he thought there needed to be more time authorized in the afternoon to cook him some home cooked meals. He also indicated that one of the workers bought him fast food because he did not know how to cook. Appellant acknowledged if the agency were to get the right workers that they should be able to get the work done in the time authorized.

The Appellant bears the burden of proving, by a preponderance of evidence that the Waiver Agency did not act properly in denying his request for additional MI Choice Waiver services. A preponderance of the material and credible evidence in this case establishes that the MI Choice Waiver Agency acted properly in denying an increase in the Appellant's MI Choice Waiver services on [REDACTED]. Considering the Appellant's actual need for services, the [REDACTED] hours of MI Choice Waiver services authorized by the Waiver Agency are sufficient to meet the Appellant's personal care needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MI Choice Waiver Agency properly denied an increase in the Appellant's MI Choice Waiver services.

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

cc: [REDACTED]

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***** 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.