

**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. 2014-35547 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., Clinical Director, appeared and testified on behalf of the Department of Community Health's Waiver Agency, the ██████████ ██████████ ("Waiver Agency" or "██████████"). ██████████, R.N., Nurse Support Coordinator also testified on behalf of the Department of Community Health's (Department) Waiver Agency.

ISSUE

Did the Department's Waiver Agency properly reduce 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, (DOB: ██████████), who is enrolled in the MI Choice Waiver Program. (Exhibit A, p. 2 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], R.N., Nurse Support Coordinator, [REDACTED], LBSW, Social Work Support Coordinator, and [REDACTED] Supervisor/Quality Improvement Manager, met with Appellant in his home and conducted a regular reassessment to determine the Appellant's current needs for services in the MI Choice Waiver Program. The Waiver agents determined that the Appellant no longer met physical eligibility on for the Waiver program. While the Appellant indicated he required limited assistance with transfers, during their visit on [REDACTED], the Appellant demonstrated the ability to easily transfer without assistance. (Exhibit A, p. 36 and testimony).
4. On [REDACTED], R.N., Nurse Support Coordinator, [REDACTED] LBSW, Social Work Support Coordinator, [REDACTED], Supervisor/Quality Improvement, Manager [REDACTED] a Manager at Impact, a Community Mental Health (CMH) contract provider, and [REDACTED] Appellant's Social Worker at [REDACTED], met with the Appellant to determine if he continued to qualify for the MI Choice waiver program, and what Waiver services, if any, he would be entitled to receive. A new Nursing Facility Level of Care Determination (LOCD) was conducted and the Appellant qualified for the program under Door 6 due to being diagnosed with a Delusional Disorder. The Waiver Agents further found that his Community Living Supports (CLS) should be reduced from [REDACTED] hours per week to [REDACTED] hours per week based on the Care Plan Worksheet completed by the Supports Coordinator, the Appellant's improved physical condition, and the fact that services were also being provided by Community Mental Health (CMH), resulting in a decreased need for MI Choice Waiver Services. (Exhibit A, pp. 2, 5-7, 34-35 and testimony).
5. On [REDACTED], a notice was sent to the Appellant indicating his CLS would be reduced from [REDACTED] hours per week to [REDACTED] hours per week effective [REDACTED] because his physical abilities had improved. (Exhibit A, p. 4 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.

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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 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.

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

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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
- 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,

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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].

The Waiver Agency provided evidence that on [REDACTED], R.N., Nurse Support Coordinator, [REDACTED] LBSW, and Social Work Support Coordinator, met with the Appellant in his home and conducted a regular reassessment to determine the Appellant's current needs for services in the MI Choice Waiver Program. [REDACTED] stated the Appellant indicated he needed limited assistance with his transfers. [REDACTED] stated, however, that while they were in the home the Appellant was able to get up on his own, and on several occasions he got up and went into the kitchen or the bathroom demonstrating that he did not need any assistance with transfers. [REDACTED] stated based on their observations the Appellant no longer met the functional eligibility requirements for the MI Choice Waiver program.

[REDACTED] stated that based on their assessment, they requested to have a supervisor go out to visit the Appellant so a new Nursing Facility Level of Care Determination (LOCD) could be conducted to see if the Appellant would qualify under another door on the LOCD. Thereafter on [REDACTED], Supervisor [REDACTED], [REDACTED] a Manager at [REDACTED], a Community Mental Health (CMH) contract provider, and [REDACTED], Appellant's Social Worker at [REDACTED], met with the Appellant to determine if he continued to qualify for the MI Choice waiver program, and what Waiver services, if any, he would be entitled to receive.

The Waiver Agents determined that Appellant did not qualify under Door 1 of the LOCD, but due to a medical diagnosis by [REDACTED], a psychiatrist at Impact, of Delusional Disorder, Appellant qualified under Door 6 on the LOCD. [REDACTED] stated that since the Appellant's physical condition had improved, and [REDACTED], the CMH contract provider was going to provide the Appellant assistance with shopping, running errands, socialization, and transportation to medical appointments, the Waiver services would be decreased and used for house cleaning, laundry, and assisting with washing the Appellant's hair. [REDACTED] stated the Appellant refused to let anyone assist him with his showers. [REDACTED] stated it was determined the Appellant's Waiver services should be reduced from [REDACTED] hours per week to [REDACTED] hours per week based on the Care Plan Worksheet she completed because of the Appellant's improved physical

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condition, and the fact that services were also being provided through CMH, resulting in a decreased need for the MI Choice Waiver Services.

On ██████████, a notice was sent to the Appellant indicating his CLS would be reduced from ██████ hours per week to █ hours per week effective ██████████ because his physical abilities had improved. The Appellant then filed a request for hearing on ██████████, to contest the reduction in his CLS services.

Appellant testified he believed that ██████████ was prejudiced against him because he had stated he did not think as a registered nurse she was qualified to manage his care. He indicated he has a third-degree black belt in martial arts and can control a lot of pain. He testified that is how he was able to get up and move around without assistance when they came to his house on ██████████. Appellant testified that a lot of the information the Waiver Agency has is from ██████████, who no longer works for ██████████ and left with no documentation of his case, so a lot of it is unfounded.

Appellant testified he has physical limitations, his feet and legs swell, it is difficult for him to move around, and he does need the assist until he can be treated for his on-going medical problems. He testified he has high blood pressure, █ stints in his heart, and has atrial fibrillation. He also claimed that the documentation submitted by the Waiver Agency omits things, and has faulty information all through it. Appellant testified that he could nit-pick the information, but chose not to do so during the hearing. He indicated he is now in a case management program at ██████████ that primarily offers him services for monitoring his mental health services, and provides him █ to █ and a █ hours per month for assistance with laundry and grocery shopping. Appellant stated Impact is not providing all the services as indicated by ██████████.

The Appellant bears the burden of proving, by a preponderance of evidence, that the Waiver Agency did not properly reduce his MI Choice Waiver services. A preponderance of the material and credible evidence in this case establishes that the MI Choice Waiver Agency acted properly when it reduced the Appellant's MI Choice Waiver services based upon the information they obtained from their ██████████ and ██████████ meetings and assessments of the Appellant. Considering the Appellant's actual need for services, the █ hours of CLS services authorized by the Waiver Agency, along with the services to be provided by CMH are sufficient to meet the Appellant's current need for care services.

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 reduced the Appellant's MI Choice Waiver services.

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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]

***** 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.