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. 2014-12747 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 Appellant's request for a hearing.

After due notice, a telephone hearing[1] commenced on and was completed on , from Participants on behalf of Appellant included , Attorney, , daughter, , and Participants on behalf of the Department of Human Services (DHS) included , Assistant Attorney General, , Hearing Facilitator, , Long Term Care Specialist, , General Services Program Manager, and , Eligibility Specialist. Participants on behalf of the MI Choice Waiver agency, HHS Health Options, (Waiver Agency) included , Director of Quality, and , Intake Evaluator.

ISSUE

Did the Waiver Agency properly determine Appellant's eligibility for 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. 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.

2. Appellant was born on , and was living in a home for the aged in . (Exhibit 4, pp. 12-14)

3. The Waiver Agency received a MI Choice Waiver Program request on , and completed an initial assessment. (Exhibit A)

[1] This hearing was held in conjunction with the related Department of Human Services Medicaid Eligibility case, MAHS Register number .

4. On , Appellant was found to meet functional eligibility requirements for the MI Choice Waiver Program through Door 1 of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). (Exhibit A)

5. The Waiver Agency forwarded an already completed Medicaid application to DHS. (Exhibit A)

6. Medicaid eligibility determinations for waiver participants are made by DHS. (Bridges Eligibility Manual (BEM) 106 p. 2)

7. On , DHS found Appellant eligible for Medicaid with a monthly deductible, or spend down, of effective . (Exhibit 6, pp. 38-40)

8. On , the Michigan Administrative Hearing System received Appellant's request for an administrative hearing. (Exhibit 1)

9. On , the Waiver Agency notified DHS that Appellant had been approved for the MI Choice Waiver Program with an enrollment date of (Exhibit 7, p. 42)

10. On , DHS, in part, found that Appellant would have full Medicaid without a spend down effective , but a divestment penalty would be applied and Medicaid would not pay for waiver services for the period of , through . (Exhibit 8, p. 43-47)

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)*

DHS policy, Bridges Eligibility Manual (BEM) 106, July 1, 2013, pp. 1-2 addresses the waiver process, including Wavier Agency responsibilities, DHS responsibilities and defines approval for the waiver:

> **Assessment**
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> The agent completes an assessment to verify medical eligibility for the waiver.
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> ***
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> Approved for the waiver means:
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> - The agent conducted the assessment, **and**
> - The participant received, or expects to receive, supports coordination services from the agent with appropriate waiver services for at least 30 consecutive days.
>
> **Approval and Termination Dates**
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> The agent determines the waiver approval date and termination date. The agent is responsible for advising the appropriate local DHS office of these dates.
>
> The waiver automatically terminates when the patient enters an LTC facility. See BEM 547 for instructions.
>
> **DHS LOCAL OFFICE RESPONSIBILITIES**
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> Local offices' primary responsibilities are doing initial asset assessments and determining MA eligibility for waiver patients.

The policy regarding enrollment in the MI Choice Waiver program is contained in the *Medicaid Provider Manual, MI Choice Waiver*, July 1, 2013, 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).

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2.1 FINANCIAL ELIGIBILITY

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by the Michigan

Department of Human Services (MDHS). As a provision of the waiver, MI Choice applicants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is furnished to participants in the special home and community-based group under 42 CFR §435.217 with a special income level equal to 300% of the SSI Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend down to achieve an enhanced financial eligibility standard. (p. 1)

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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. (p. 3)

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SECTION 3 – ENROLLMENT

MI Choice waiver agencies determine the enrollment and termination dates for each participant for whom they provide waiver services. No applicant shall be granted enrollment status without fully meeting all eligibility requirements. (p. 5)

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SECTION 4 - SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. (p. 9)

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Services must not be provided unless they are defined in the plan of service and must not precede the establishment of a plan of service. (p. 9)

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4.1.Q. RESIDENTIAL SERVICES

MI Choice participants who receive Residential Services must reside in a home-like, noninstitutional setting licensed by the State of Michigan. As a stipulation of the licensure standards, such settings provide continuous on-site response capability to meet scheduled or unpredicted resident needs and provide supervision, safety, and security. Residential Services include enhanced assistance with activities of daily living and supportive services that rise above the level of service mandated by licensing requirements. Residential services are intended to supplement the existing level of services provided in licensed settings, particularly labor intensive activities, which are above the scope of service normally provided. Residential services are authorized to prevent the institutionalization of the participant.

Additional assistance can include assisting, reminding, cueing, observing, guiding or training in activities of daily living (such as bathing, eating, dressing, or personal hygiene), assistance, support or guidance with such activities as non-medical care (not requiring nurse or physician intervention), special homemaking needs, social participation, relationship maintenance and building community connections to reduce personal isolation, participation in regular community activities incidental to meeting the participant's community living preferences, attendance at medical appointments, and staff assistance with preserving the health and welfare of the participant in order that they may reside and be supported in the most integrated independent community setting.

Third parties can only provide Residential Services with the approval of the participant, licensee, and waiver agency. Payment for Residential Services excludes room and board costs, items of comfort and convenience, costs of facility maintenance, upkeep, and improvement, or other costs that are required as a term of licensure. Residential Service providers are limited to billing under a discrete set of Healthcare Common Procedure Coding System (HCPCS) codes for their services.

Residential Services cannot be provided in circumstances in which they would duplicate services available elsewhere or are available under the State Plan. The distinction must be apparent by unique hours and units in the approved service plan. (pp. 15-16)

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8.4 CLAIMS REPORTING

Medicaid is established as the payer of last resort. Waiver agencies must pursue and secure all third party liability (TPL) sources possible. (p. 26)

DHS policy, Bridges Eligibility Manual (BEM) 405, July 1, 2013, pp. 13-14 addresses the computing the divestment penalty period when there is MI Choice Waiver eligibility:

> The penalty is applied to the months (or days) an individual is eligible for Medicaid and actually in LTC, Home Health, Home Help, or the MIChoice Waiver. The divestment penalty period cannot be applied to a period when the individual is not eligible for Medicaid for any reason (that is the case closes for any reason or is eligible for Medicaid but is not in LTC, Home Help, Home Health, or the MIChoice Waiver. Restart the penalty when the individual is again eligible for Medicaid and in LTC, Home Help, Home Health, or MIChoice Waiver. When a medical provider is paid by the individual, or by a third party on behalf of the individual, for medical services received, that month is not a penalty month. That month cannot be counted as part of the penalty period. This does not include payments made by commercial insurance or Medicare. (p. 13)
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> ***
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> The 1st day the client is eligible to receive MA coverage for LTC, MIChoice, home help, or home health services is the 1st day after the penalty period ends. (p. 13)
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> ***
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> The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, or home help or home health services), and is not already part of a penalty period. When a medical provider is paid by the individual, or by a a third party on behalf of the individual, for medical services received, the individual is not eligible for Medicaid in that month and the month is not a penalty month. That month cannot be counted as part of the penalty period. This does not include payments made by commercial insurance or Medicare. (p. 14)

In this case, it was uncontested that Appellant would have a divestment penalty for his Medicaid case. The length of the divestment penalty period was also uncontested. Appellant contests the dates the divestment penalty period were imposed. Appellant believes the divestment penalty period should have started in in [redacted], after the initial assessment for the MI Choice Waiver program was completed. The related Waiver Agency's actions in determining MI Choice Waiver eligibility will be addressed in this Decision and Order. The related DHS actions in determining Medicaid eligibility will be addressed in a separate Hearing Decision for MAHS register number [redacted]

The initial assessment for the MI Choice Waiver program was completed on [redacted], and Appellant was found to meet functional eligibility requirements for the MI Choice Waiver Program through Door 1 of the LOCD. (Exhibit A) However, this was only one of the three eligibility criteria for the MI Choice Waiver Program.

Financial eligibility and the need for at least one waiver service were also required. (*Medicaid Provider Manual, MI Choice Waiver,* July 1, 2013, p.1)

The , Notice of Case Action indicates DHS initially determined Appellant was eligible for Medicaid with a monthly spend down of effective . (Exhibit 6, pp. 38-40) From an , email from the DHS Long Term Care Specialist, it appears that in part, the spend down determination was based on a communication with the Waiver Agency that they had not yet approved Appellant for the waiver because they had understood he could not be approved if he had a divestment penalty. (Exhibit I)

It was not until , that the Waiver Agency notified DHS that Appellant was approved for the MI Choice Waiver with an enrollment date of (Exhibit 7, p. 42) It was not clear what specifically occurred in early that triggered the Waiver Agency to approve Appellant with this enrollment date. The Waiver Agency witnesses testified their case notes show additional information was received, but do not specify what the additional information was.

The testimony and documentary evidence indicate that between the MI Choice Waver Agency staff and the DHS staff initially involved, there was confusion about how the MI Choice Wavier enrollment would work with a Medicaid divestment penalty. However, it does not appear that the confusion regarding the divestment penalty issue was the sole cause of the delay from the , initial assessment to the MI Choice Waiver enrollment. As noted above, the financial eligibility requirement was not the only additional MI Choice Waiver program eligibility criteria Appellant still needed to meet after the initial assessment. Appellant also had to meet the additional requirement of having a need for at least one MI Choice Waiver service over and above any services that were included with his room and board at the home for the aged. (*Medicaid Provider Manual, MI Choice Waiver,* July 1, 2013, pp.1 and 15-16)

The testimony of the Waiver Agency witnesses indicated that after the , initial assessment, the Waiver Agency was also awaiting additional information to determine whether or not Appellant had a need for a waiver service over and above the scope of service(s) normally provided with his room and board. Some of the testimony indicated the waiver services determination was not completed until a assessment. If the criteria that Appellant had a need for a waiver service over and above the customary services included with his room and board was not completed until the assessment, then the approval and enrollment in the MI Choice Waiver was actually premature. As noted above, the case notes the Waiver Agency witnesses reviewed during the hearing proceedings did not specify what additional information was received in early . It is possible that at least part of the additional information the wavier agency received addressed Appellant's need for a waiver service. If so, the , approval and enrollment date was appropriate.

Ultimately, the evidence does not definitively establish that Appellant met all three eligibility criteria to be approved for the MI Choice Waiver program as of the initial assessment date. Accordingly, the Waiver Agency determination to approve Appellant for the MI Choice Waiver with an enrollment date of , is upheld.

The testimony of Appellant's family members indicated they paid for services in the months they asserted should have been covered by the MI Choice Waiver program had Appellant been approved and enrolled earlier, and thus the divestment penalty period would have been applied and ended earlier. The Waiver Agency Director of Quality pointed out the above cited Medicaid Provider Manual policy provisions do not allow for waiver services to be approved retrospectively. Policy directs that waiver services must not be provided unless they are defined in the plan of service and must not precede the establishment of a plan of service. *Medicaid Provider Manual, MI Choice Waiver,* July 1, 2013, p. 9. Accordingly, there is no way for the Waiver Agency to reimburse Appellant's family for the services they paid for during any months prior to the waiver program enrollment as there would not have been an established plan of services.

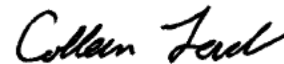
It is also noted that Medicaid is a payer of last resort. *Medicaid Provider Manual, MI Choice Waiver,* July 1, 2013, p. 26. Thus, if there were third party resources that could cover the supplemental services, these would have to have been pursued prior to the MI Choice Waiver program covering the services. Lastly, the policy also specifies that any month(s) a third party pays a provider for services cannot be counted as a penalty month. (*Medicaid Provider Manual, MI Choice Waiver,* July 1, 2013, pp. 13-14)

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Waiver Agency properly determined Appellant's eligibility for the MI Choice Waiver Program.

IT IS THEREFORE ORDERED that:

The Waiver Agency's decision is AFFIRMED.



Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

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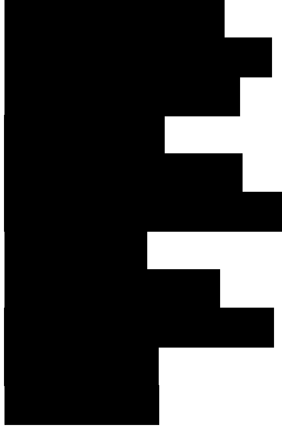

***** NOTICE *****

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. 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.