STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
Phone: (877)-833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No.: 15-019466-EDW

[redacted],
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 hearing was held on [redacted] Appellant appeared and offered testimony on his own behalf.

[redacted], Director of [redacted], appeared on behalf of the Department's Waiver agency, the [redacted] (Waiver Agency of [redacted], Social Worker, Janette Vanderveen, Clinical Manager and [redacted] R.N., Case Manager appeared as witnesses for the Waiver Agency.

ISSUE

Did the Waiver Agency properly close the Appellant's MI Choice Waiver case and later determine that the Appellant was not eligible 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. As of [redacted], the Appellant was receiving services through the MI Choice Waiver Program. (Testimony)

2. On [redacted], the Appellant contacted [redacted] and indicated he was no longer living with his live-in caregiver and requested his mother become his paid caregiver through self-determination. (Exhibit A, p 3; Testimony)

3. On [redacted], the Appellant's former caregiver called [redacted] and indicated she would be refusing payment as she stopped providing services to the Appellant [redacted] weeks prior and didn't want to be accused of committing Medicaid fraud. The former caregiver mentioned during the conversation that the Appellant could do more for himself. (Exhibit a, p 3; Testimony)

4. [redacted] policy requires that when there are allegations of Medicaid fraud an investigation is to be conducted. During the investigation, the MI Choice Waiver participant is permitted to continue receiving services but not through self-determination. (Testimony)

5. On [redacted] notified the Appellant of the fraud allegation by his former caregiver and indicated he would be permitted to continue receiving uninterrupted service through traditional waiver services or have his mother be hired by the Agency but that they could not permit him to continue receiving services through self-determination while the investigation was being completed. The Appellant refused the offer and elected to stop receiving services and opted to seek services through his local Department of Health and Human Services (DHHS) office instead. (Exhibit A, p 3; Testimony)

6. On [redacted] sent the Appellant an Adequate Action Notice suspending the Appellant's services per his election. (Exhibit A, pp 3, 7; Testimony)

7. On [redacted] closed the Appellant's case. (Exhibit A, p 3; Testimony)

8. On [redacted] the Appellant contacted [redacted] and requested self-determination services and that his mother be his paid caregiver but that he was not interested in being added to the MI-Choice Waiver list for an assessment. (Exhibit A, p 3; Testimony)

9. On [redacted], the Michigan Administrative Hearing System received Appellant's request for an administrative hearing. (Testimony)

10. On [redacted], [redacted] and [redacted], LBSW, visited the Appellant and the Appellant's mother for a Nursing Facility Level of Care (NFLOC) determination. (Exhibit A, pp 3, 10-17; Testimony)

11. During the [redacted] determination, the Appellant indicated he was independent in toileting and eating and needed supervision with bed mobility and transfers; indicated he had zero physician visits and zero physician order change within the prior 1[redacted] days. (Exhibit A, pp 10-13; Testimony)

12. On [redacted] upon completion of the determination, [redacted] indicated the Appellant did not qualify medically for the MI-Choice Waiver program and indicated he could follow up with his primary care physician regarding the application of skin creams. (Exhibit A, pp 3, 4; Testimony)

13. On [redacted] sent the appellant an Adequate Negative Action notice indicating the Appellant did not qualify medically for the MI-Choice Waiver program. (Exhibit A, pp 4, 9; Testimony)

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 Health and Human Services (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)*

The policy regarding enrollment in the MI Choice Waiver program is contained in the *Medicaid Provider Manual, MI Choice Waiver*, April 1, 2015, 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, emphasis added).

* * *

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
- 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).

In order to be found eligible for MI Choice Waiver services, Appellant must meet the requirements of at least one Door. The Waiver Agency presented testimony and documentary evidence that Appellant did not meet any of the criteria for Doors 1 through 7.

Door 1
Activities of Daily Living (ADLs)

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.

(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:
- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

(D) Eating:
- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

~~ Guidelines for ADL Performance ~~

- Do not confuse an applicant who is totally dependent in an ADL activity with one where the activity itself is not occurring. For example, an applicant who receives tube feedings and no foods or fluids by mouth is engaged in eating, and must be evaluated under the eating category for his/her level of assistance in the process.

- An applicant who is highly involved in providing him/herself a tube feeding is not totally dependent and should not be coded as "total dependence," but rather as a lower code depending on the nature of help received from others.

- Each of the ADL performance codes is exclusive; there is no overlap between categories. Changing from one category to another demands an increase or decrease in the number of times help is provided.

EXAMPLE	CODE
Bed Mobility: Mrs. P has been alone without informal support in the community for the last two weeks and is unable to physically turn, sit up or lay down in bed on her own. She presents with stage 3 pressure sores related to the lack of personnel to assist.	**Activity Did Not Occur**
Transfers: Mr. Q routinely sleeps in his reclining chair. He is able to maintain his body position as desired, although he doesn't physically turn to his side.	**Independent**
Transfers: Mrs. B is ventilator dependent and, because of many new surgical sites, she must remain on total bed rest.	**Activity Did Not Occur**

Michigan Medicaid Nursing Facility Level of Care Determination
Field Definition Guidelines, June 7, 2015, p 2.

Appellant was found to be independent with eating and toilet use and required supervision with bed mobility and transferring. As such, Appellant did not qualify under Door 1.

Door 2
Cognitive Performance

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

Appellant was found to have no short-term memory problems, independent with cognitive skills and daily decision making and was able to make himself understood without assistance. As such, Appellant did not qualify under Door 2.

Door 3
Physician Involvement

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3

1. At least one Physician Visit exam AND at least four Physicians Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physicians Order changes in the last 14 days.

Appellant reported 0 physician's visits but 0 physician change orders within the 14-day period leading up to the LOC Determination. As such, Appellant did not qualify under Door 3.

Door 4
Treatments and Conditions

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories above and have a continuing need to qualify under Door 4.

In order to qualify under Door 4 the applicant must receive, within 14 days of the assessment date, any of the following health treatments or demonstrated any of the following health conditions:

A. Stage 3-4 pressure sores
B. Intravenous or parenteral feedings
C. Intravenous medications
D. End-stage care
E. Daily tracheostomy care, daily respiratory care, daily suctioning
F. Pneumonia within the last 14 days
G. Daily oxygen therapy
H. Daily insulin with two order changes in last 14 days
I. Peritoneal or hemodialysis

Appellant did not report any of the treatments or conditions found in policy. Accordingly, Appellant did qualify under Door 4.

Door 5
Skilled Rehabilitation Therapies

Scoring Door 5: The applicant must have required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

Appellant was not currently receiving any skilled rehabilitation therapies at the time of the assessment. Accordingly, Appellant did not qualify under Door 5.

Door 6
Behavior

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

1. A "Yes" for either delusions or hallucinations within the last 7 days.

2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

Appellant did not have any delusions or hallucinations within seven days of the LOC Determination. Appellant did not exhibit any of the challenging behaviors associated with Door 6 within the 7 days prior to the assessment. Accordingly, Appellant did not qualify under Door 6.

Door 7
Service Dependency

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency under Door 7.

The LOC Determination provides that Appellant could qualify under Door 7 if he is currently (and has been a participant for at least one (1) year) being served by either the MI Choice Program, PACE program, or Medicaid reimbursed nursing facility, requires ongoing services to maintain current functional status, and no other community, residential, or informal services are available to meet the applicant's needs.

Here, Appellant has not been a participant in the Waiver Program for at least one year. The Appellant had a break in services prior to the assessment and the Appellant's needs could be met by both his informal supports and through assistance from his primary care physician. As such, Appellant did not qualify under Door 7.

6.3 SELF-DETERMINATION

Self-Determination provides MI Choice participants the option to direct and control their own waiver services. Not all MI Choice participants choose to participate in self-determination.

A waiver agency may terminate self-determination for a participant when problems arise due to the participant's inability to effectively direct services and supports. Prior to terminating a self-determination agreement (unless it is not feasible), the waiver agency informs the participant in writing of the issues that have led to the decision to terminate the arrangement. The waiver agency will continue efforts to resolve the issues that led to the termination. (pp 28, 29)

* * *

Appellant argued that he is not independent and that he was hospitalized at the University of Michigan during the seven days immediately preceding the [redacted] determination. The testimony however of [redacted] witnesses do not

reflect that information was ever communicated to them during the assessment and further the Appellant did not provide any documentation to substantiate his claims.

Additionally, the Appellant offered very little argument as to what happened during [redacted] when his case was closed and it was alleged he refused services when his self-determination request was denied due to the pending/ongoing investigation regarding Medicaid fraud. As a result, I find no choice but to find that more likely than not, the Appellant did opt to refuse services and pursue assistance through DHHS when [redacted] indicated he could no longer have self-determination services during the time of the investigation. Furthermore, I find [redacted] was permitted per the MPM to suspend self-determination services due to the allegations of fraud. The allegations are a problem that indicates the Appellant had an issue that affected his ability to effectively direct services and supports.

Moreover, based on the information at the time of the LOC determination, Appellant did not meet the Medicaid nursing facility level of care criteria. This does not imply that Appellant does not need any assistance, or that he does not have any medical problems, only that he was not eligible to receive services through the MI Choice Waiver Program at the time of the assessment. Accordingly, the Waiver Agency properly determined that Appellant was not eligible for MI Choice Waiver services.

Appellant did not prove by a preponderance of evidence that the Waiver Agency erred in finding him ineligible for the MI Choice Waiver Program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly determined Appellant was not eligible for the MI Choice Waiver Program and properly closed the Appellant's case in [redacted]

IT IS THEREFORE ORDERED that:

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

Corey Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

[redacted]
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Decision and Order

CAA/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.