



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[REDACTED]
Date Mailed: November 22, 2016
MAHS Docket No.: 16-011615
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a hearing was held on November 17, 2016. [REDACTED], appeared and offered testimony on behalf of the Petitioner. The Petitioner also appeared and offered testimony. [REDACTED], Waiver Supervisor, appeared on behalf of the [REDACTED] (Department). [REDACTED], R.N., Quality Manager, appeared as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Waiver Agency properly deny Petitioner's request for services through 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. Petitioner is a [REDACTED] year old female who applied for waiver services with the Department through the MI Choice Waiver Program. (Exhibit A, p. 1; Testimony).
2. On May 24, 2016, Department staff performed a Level of Care Determination (LOCD) with Petitioner. (Exhibit A, pp. 1-33; Testimony).
3. Petitioner passed through Door 4 of the LOCD based on the Petitioner's daily oxygen therapy. (Exhibit A, pp. 6, 33; Testimony).

4. As of May 24, 2016, the Petitioner did not demonstrate a continuing need for and use of at least two covered MI Choice services. (Exhibit A, p. 33; Testimony).
5. As of May 24, 2016, the Petitioner had no Activity of Daily Living (ADL) needs and was able to drive herself to and from the store and hair appointments. (Exhibit A, p. 30).
6. On May 25, 2016, the Department sent the Petitioner an Adequate Action notice. The notice indicated the Petitioner did not qualify for Waiver services.
7. On August 25, 2016, the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed in this matter.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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:

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 CFR 430.0

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State...

42 USC 1396n(b)

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Petitioner is seeking services through the Department's Home and Community Based Services for Elderly and Disabled. The waiver is called MI Choice in Michigan. The program is funded through the Federal Centers for Medicare and Medicaid to the Michigan Department of Health and Human Services. Regional agencies, in this case AAA, 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 Medicaid Provider Manual (MPM) outlines the governing policy for the MI Choice Waiver program and, with respect to functional eligibility, the applicable version of the MPM states in part:

2.2 FUNCTIONAL ELIGIBILITY

The MI Choice waiver agency must verify an applicant's medical/functional eligibility for program enrollment by inputting a valid Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) into the online LOCD application. A valid LOCD is defined as an LOCD that was completed in-person with the applicant according to MDCH policy and put in the online LOCD application within 14 calendar days after the date of enrollment into the MI Choice program. (Refer to the Directory Appendix for website information.) The LOCD is discussed in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter. Additional information can be found in the Nursing Facility Coverages Chapter and is applicable to MI Choice applicants and participants.

The applicant must also demonstrate a continuing need for and use of at least two covered MI Choice services, one of which must be Supports Coordination. This need is originally established through the Initial Assessment using the process outlined in the Need for MI Choice Services subsection of this chapter.

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 person completing the LOCD must either be waiver agency staff or in the waiver agency's provider network.

The online version of the LOCD must be completed within 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.

MPM, October 1, 2015 version
MI Choice Waiver Chapter, pages 1-2

Accordingly, based on the above policy, Petitioner must qualify for functional eligibility through one of seven doors on a continuing basis and, if Waiver Agency staff determines that she no longer meets the functional level of care criteria for participation, another face-to-face online version of the LOCD must be conducted reflecting the change in functional status.

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

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."

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 Physician Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

Door 4
Treatments and Conditions

Scoring Door 4: The applicant must score “yes” in at least one of the nine categories above [Stage 3-4 pressure sores; Intravenous or parenteral feedings; Intravenous medications; End-stage care; Daily tracheostomy care, daily respiratory care, daily suctioning; Pneumonia within the last 14 days; Daily oxygen therapy; Daily insulin with two order changes in last 14 days; Peritoneal or hemodialysis] and have a continuing need to 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.

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.

Door 7
Service Dependency

Scoring Door 7: The applicant must be a current participant [and has been a participant for at least one (1) year] and demonstrate service dependency under Door 7.

In this case, the Petitioner qualified under Door 4 but did not demonstrate a continuing need for and use of at least two covered MI Choice services.

The Petitioner in response argued that she gets winded going up and down stairs. This in and of itself does not show a need for assistance nor does it demonstrate a need for and use of at least two covered MI Choice services.

Given the undisputed evidence in this case, Petitioner has failed to meet her burden of proof and the Department's decision must be affirmed. Accordingly, the Department properly denied Petitioner's request for services pursuant to the above policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department correctly denied the Petitioners request for services.

IT IS THEREFORE ORDERED that

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

CA/sb



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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

[REDACTED]

DHHS -Dept Contact

[REDACTED]
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Petitioner

[REDACTED]

Community Health Rep

[REDACTED]

Authorized Hearing Rep.

[REDACTED]