[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: September 22, 2020
MOAHR Docket No.: 20-005130
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on September 9, 2020. [redacted], Petitioner's Case Worker at Ottawa County Community Mental Health, appeared and testified on Petitioner's behalf. Sheyenne Cole, MI Choice Waiver Director, appeared and testified on behalf of Respondent, Senior Resources of West Michigan.

During the hearing, the following exhibits were entered into the record:

Exhibit A: Request for Hearing
Exhibit #1: Adequate Action Notice
Exhibit #2: Progress Notes
Exhibit #3: MI Choice Assessment
Exhibit #4: Medical Notes

ISSUE

Did the Respondent properly deny Petitioner's request for 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. Respondent is a contract agent of the MDHHS and is responsible for waiver eligibility determinations and the provision of MI Choice waiver services in its service area.

2. Petitioner is a [redacted] ([redacted]) year-old Medicaid beneficiary who has been

diagnosed with, among other conditions, bipolar disorder and renal failure. (Exhibit #3, pages 5-6).

3. In July of 2020, Petitioner applied for services through Respondent. (Exhibit #2, page 4).

4. At that time, Petitioner was already approved for and receiving services through Ottawa County Community Mental Health. (Exhibit #2, pages 3-4).

5. On July 16, 2020, Respondent completed its initial assessment of Petitioner. (Exhibit #2, page 3; Exhibit #3, pages 1-12).

6. In that assessment, Petitioner was found eligible for MI Choice Waiver Services through Respondent. (Exhibit #3, pages 1-12).

7. Respondent then began the process of approving specific services for Petitioner, including Community Living Supports and transportation. (Exhibit #2, pages 2-3).

8. However, upon further review, Respondent determined that all the services it would approve could be provided by other supports available to Petitioner. (Testimony of Respondent's representative).

9. On July 22, 2020, Respondent sent Petitioner written notice that his request for services had been denied. (Exhibit #1, page 1).

10. With respect to the reason for the denial, the notice stated: "There is no medical necessity for a long-term service as your needs are more appropriately being met by Community Mental Health". (Exhibit #1, page 1).

11. On August 11, 2020, the Michigan Office of Administrative Hearings and Rules received the request for hearing filed in this matter with respect to the decision to deny his request for services. (Exhibit A, pages 1-9).

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. 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.

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 (formerly

HCFA) to the Department. Regional agencies, in this case Respondent, 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)*

With respect to eligibility for the MI Choice Waiver Program, the Medicaid Provider Manual (MPM) states in part:

> **SECTION 2 – ELIGIBILITY**
>
> The MI Choice program is available to persons who are either elderly (age 65 or older) or adults with disabilities aged 18 or older and meet the following eligibility criteria:
>
> - An applicant must establish their financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.
> - Must be categorically eligible for Medicaid as aged or disabled.
> - 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 requires at least two waiver services, one of which must be Supports Coordination, and that the service needs of the applicant cannot be fully met by existing State Plan or other services.
>
> All criteria must be met 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.

2.1 FINANCIAL ELIGIBILITY

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by MDHHS. 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 available to participants in the special home and community-based group under 42 CFR §435.217 with a special income level up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend-down to the income limit to become financially eligible for MI Choice.

To initiate a financial eligibility determination, MI Choice waiver agencies must enter enrollment notifications electronically in the Community Health Automated Medicaid Processing System (CHAMPS). Once the electronic enrollment is completed in CHAMPS, the participant will be assigned an associated MI Choice Program Enrollment Type (PET) code. MI Choice waiver agencies must enter disenrollment notifications electronically in CHAMPS to notify MDHHS of participants who are no longer enrolled in MI Choice. Once an electronic disenrollment is completed in CHAMPS, the participant's PET code will end to reflect a disenrollment date. Proper recordkeeping requirements must be followed and reflected in the applicant's or participant's case record.

2.2 FUNCTIONAL ELIGIBILITY

The MI Choice waiver agency must verify an applicant's functional eligibility for program enrollment using the LOCD application in CHAMPS. Waiver agencies must conduct an LOCD in person with an applicant and submit that information in the LOCD application in CHAMPS, or the agency may adopt the current existing LOCD conducted by another provider. The information submitted is put through an algorithm within the application to determine whether the applicant meets LOCD criteria. Only the LOCD application in CHAMPS can determine functional eligibility for the nursing facility level of care. Additional information can be found in

the Nursing Facility Level of Care Determination Chapter and is applicable to MI Choice applicants and participants.

2.2.A. FREEDOM OF CHOICE

Prior to MI Choice enrollment, all applicants and their legal representatives must be given information regarding all Medicaid long-term services and supports options for which they qualify through the nursing facility LOCD, including MI Choice, Nursing Facility, MI Health Link, and the Program of All-Inclusive Care for the Elderly (PACE). Qualified applicants may only enroll in one long-term services and supports program at any given time. Nursing facility, PACE, MI Choice, MI Health Link, and Adult Home Help services cannot be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options via the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the supports coordinator and the applicant (or their legal representative) seeking services and is to be maintained in the applicant's case record and provided to the applicant or participant upon request.

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 two covered services, one of which must be Supports Coordination, as determined through an in-person assessment and the person-centered planning process. Applicants must also agree to receive MI Choice services on a regular basis, at least every 30 days.

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 Medicaid 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.
>
> *MPM, July 1, 2020 version*
> *MI Choice Waiver Chapter, pages 1-3*

Here, Respondent denied Petitioner's request for services pursuant to the above policies and on the basis that Petitioner's service and support needs could be fully met through the intervention of State Plan or other available Medicaid services.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, Petitioner has failed to meet that burden of proof and Respondent's decision must be affirmed.

It is undisputed that Petitioner meets the financial and functional eligibility requirements outlined in the above policies, but that alone is insufficient for Respondent to authorize services. It must also be established that his service needs cannot be fully met by existing State Plan or other services, and the record fails to establish such circumstances in this case.

Respondent's representative credibly and fully explained both what services would have been approved through Respondent and how those services can be provided through other supports, especially the local Community Mental Health authority. Moreover, Petitioner's representative, who works at the local Community Mental Health authority, did not identify any needs that are not being met at this time.

Petitioner's representative did question whether the service interventions would be sufficient in the future to meet Petitioner's needs, but that does not suggest that services are currently needed through Respondent and, as also acknowledged by Respondent's representative, Petitioner is always free to reapply for services through Respondent if his circumstances change or his needs are not being met.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for services.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS Department Rep.

Heather Hill
400 S. Pine 5th Floor
Lansing, MI
48933

DHHS -Dept Contact

Brian Barrie
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DHHS -Dept Contact

Elizabeth Gallagher
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Petitioner

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Community Health Rep

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Authorized Hearing Rep.

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