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: June 30, 2017
MAHS Docket No.: 17-005826
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 upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 7, 2017. [redacted], Petitioner's son, appeared and testified on Petitioner's behalf. Petitioner was also present for the hearing. [redacted], Associate Specialist for Appeals and Grievances, appeared and testified on behalf of [redacted], the Respondent Integrated Care Organization (ICO).

During the hearing, the parties submitted one exhibit that was entered into the record:

Exhibit #1: Request for Hearing

ISSUE

Did Respondent properly deny Petitioner's request for Long Term Support Services (LTSS)?

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 an Integrated Care Organization (ICO) contracted by the Michigan Department of Health and Human Services

[1] This matter was initially docketed with Petitioner's son/representative as the named petitioner. During the hearing, the parties confirmed that Petitioner was the enrollee and the case concerned his enrollment and services.

(Department or DHHS) and the Centers for Medicare & Medicare Services (CMS) to provide covered services through the MI Health Link managed care program.

2. Petitioner is a Medicaid/Medicare beneficiary who has been enrolled in the MI Health Link program through Respondent at various times. (Testimony of Petitioner's Representative; Testimony of Respondent's Representative).

3. On May 8, 2017, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, page 1).

4. In that request, Petitioner asserted that Respondent improperly dropped him from coverage for the months of July of 2016 to November of 2016, and failed to pay for support services provided by his son during the months of January of 2017 to March of 2017. (Exhibit 1, page 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.

This case involves the MI Health Link managed care program and, with respect to that program, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 1 – GENERAL INFORMATION**
>
> Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.
>
> MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term

supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.

MPM, January 1, 2017 version
MI Health Link Chapter, page 1
(Emphasis added)

SECTION 3 – ENROLLMENT PROCESS

Enrollment in the MI Health Link program occurs in two ways: 1) voluntary enrollment, and 2) passive enrollment. For voluntary enrollment, the eligible individual must call the enrollment broker contracted by the state for Medicaid managed care programs. The individual selects the ICO in which they wish to enroll, using the ICO provider networks and drug formularies to assist in making choices.

Eligible individuals who do not voluntarily enroll in the program will receive a notification letter at least 60 days prior to the enrollment effective date informing them they will be passively enrolled. Eligible individuals will have a period of 60 days to opt out of the program if they choose to do so prior to the enrollment effective date. Individuals may opt out by calling the entities as indicated in the notification letter. Individuals who do not opt out of the program prior to the effective date will be passively enrolled and an ICO will be assigned to them. Prior to the enrollment effective date, and at any time thereafter, individuals will have the opportunity to select a different ICO than the one assigned to them if there is another ICO option in the region.

After enrollment, individuals are issued an identification (ID) card that is specific to the MI Health Link program. This ID card is used instead of the traditional Medicare and Medicaid ID cards, and identifies the name of the ICO responsible for coverage along with the MI Health Link logo. Individuals will be enrolled in the benefit plan called ICO-MC, which is a benefit plan specific to the MI Health Link program. (Refer to the Beneficiary Eligibility Chapter for additional information.)

Individuals who are enrolled in the MI Choice waiver or the Program of All-Inclusive Care for the Elderly (PACE) are not passively enrolled into MI Health Link. These individuals may enroll in MI Health Link voluntarily, but must disenroll from MI Choice or PACE before the MI Health Link enrollment is effective. MDHHS will assist in this process to ensure a smooth transition between programs. Individuals who are enrolled in MI Choice or PACE and wish to enroll in MI Health Link must call the enrollment broker to start the enrollment process. The enrollment broker will send a message to MDHHS notifying MDHHS that the individual has chosen to enroll in MI Health Link. MDHHS staff will contact the appropriate MI Choice waiver agency or PACE organization to obtain current information and assessments for the individual. MDHHS will review the information received to determine if the individual's needs can be met through MI Health Link. MDHHS will contact the individual to discuss whether his/her needs can be met in MI Health Link. If the individual still chooses to join MI Health Link at that time, MDHHS will initiate the formal enrollment in the program and will notify the ICO accordingly.

Individuals may choose to disenroll from MI Health Link at any time. Disenrollment is effective on the first day of the following month.

MPM, January 1, 2017 version
MI Health Link Chapter, page 3
(Emphasis added)

SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy

- Medicaid State Plan services, including personal care services

- Dental services

- Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.

- Long Term Supports and Services (LTSS)

- Nursing facility services

- State Plan personal care services

- Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.

- MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD

- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

Hospice is not a covered benefit. If an individual elects to receive hospice services, the individual is disenrolled from the ICO effective the last day of the same month in which the hospice enrollment is effective. For example, if the individual elects to receive hospice services on March 15, he/she will be disenrolled from MI Health Link effective April 1. The ICO is responsible for non-hospice related services until the individual is disenrolled from the ICO (the remainder of the month). After disenrollment from the ICO, the individual's option for Medicaid services in the demonstration regions will be through fee-for-service (FFS). Medicare will cover the hospice services as well as any other non-hospice related services traditionally covered by Medicare. Individuals will not be eligible for the MI Health Link program as long as they continue to be enrolled in hospice.

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission

requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

MPM, January 1, 2017 version
MI Health Link Chapter, page 5
(Emphasis added)

SECTION 7 – CARE COORDINATION, ASSESSMENT AND PERSON-CENTERED PLANNING

The MI Health Link program requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, BH, SUD and/or I/DD, pharmacy, and LTSS. This requires coordination between the ICO and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable. The ICO shall contract with the PIHP to deliver Medicare BH, SUD and/or I/DD services to individuals. This contract and any other downstream contracts related to care coordination activities will be monitored by the CMS and MDHHS contract management team to ensure all delivery system requirements of MI Health Link are met and all individuals receive the appropriate care coordination services. To accomplish this, the ICO must:

- Develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative claims data, and other available information to help prioritize and determine the care coordination needs of each individual.

- Focus on providing services in the most integrated and least restrictive setting.

- Maintain flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.

- Exhaust the use of community-based services before utilizing institutional settings for LTSS.

- Wherever possible, include a person familiar with the needs, circumstances and preferences of the individual when the individual is unable to participate

fully in or report accurately to the Integrated Care Team (ICT).

- Ensure that the individual has a primary care provider (PCP) appropriate to meet his or her needs and assist the individual in accessing services.

MPM, January 1, 2017 version
MI Health Link Chapter, page 37
(Emphasis added)

SECTION 15 – APPEALS

The three-way contract establishes individual notice and appeal rights that must be adhered to when any grievable or adverse action is taken by the ICO or contracted entities that would fall under the grievance or appeals processes available to individuals through Medicare and Medicaid guidelines.

MPM, January 1, 2017 version
MI Health Link Chapter, page 63

Here, Petitioner asserted in his request for hearing and Petitioner's representative testified during the hearing that Respondent improperly dropped Petitioner from coverage for the months of July of 2016 to November of 2016 and failed to pay for support services provided by his son during the months of January of 2017 to March of 2017. Petitioner's representative also testified that Petitioner never voluntarily disenrolled from the MI Health Link program and that Petitioner's representative provided all necessary services. Petitioner's representative further testified that Petitioner never declined any assessments requested by Respondent.

In response, Respondent's testified that there were no denials on file for Petitioner and that Respondent's enrollment department had informed her that the Centers for Medicare & Medicaid Services (CMS) had informed it that Petitioner has voluntarily disenrolled from the program and only had MI Health Link coverage for March of 2017. She also testified that Petitioner was contacted in March of 2017 in order to complete the assessment process for receiving LTSS, but that Petitioner declined such an assessment.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for LTSS.

Given the limited record in this case, the undersigned Administrative Law Judge finds that Petitioner has met that burden of proof and that Respondent's decision must be reversed at this time. The record in this case is largely silent, with neither party

submitting any documentation other than the request for hearing, but Petitioner's representative credibly testified that Petitioner has both consistently requested LTSS services and never disenrolled from that program, and that testimony is essentially uncontradicted. Respondent's representative and sole witness lacks any personal knowledge of the facts relevant to this case, she relies solely on hearsay, and Respondent failed to produce any evidence regarding Petitioner's alleged disenrollment from the plan or declining of any assessment.

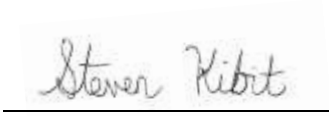
However, while the undersigned Administrative Law Judge finds that, on the basis of the limited record before him, that Respondent has erred, it is not clear that LTTS should have been approved and Petitioner submitted no evidence regarding any coverage through the MI Health Link Program or requests for services. Accordingly, the undersigned Administrative Law Judge will only order that Respondent initiate a reassessment of Petitioner's request for services.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent erred in denying Petitioner's request for LTSS.

IT IS, THEREFORE, ORDERED that:

> Respondent's decision is **REVERSED** and it must initiate a reassessment of Petitioner's request.



SK/db

Steven Kibit
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]

Community Health Rep

[redacted]

Petitioner

[redacted]