[redacted]

Date Mailed: February 14, 2018
MAHS Docket No.: 17-015040
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, and following a prehearing conference, a telephone hearing was held on January 31, 2018. [redacted]., Petitioner's son, appeared and testified on Petitioner's behalf. Petitioner was also present for the hearing. [redacted] Associate Grievance and Appeal Specialist, appeared and testified on behalf of [redacted], the Respondent [redacted] (ICO). [redacted], Respondent's Manager for the [redacted], also testified as a witness for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-7. No other exhibits were admitted.

ISSUE

Did the Respondent improperly fail to pay for Long Term Support Services (LTSS) for Petitioner during the time periods of July of 2016; the last two weeks of September of 2016; October of 2016; the first two weeks of November of 2016; January of 2017; and February of 2017?

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 (Department or DHHS) and the Centers for Medicare & Medicare Services (CMS) to provide covered services through the [redacted] managed care program.

2. Petitioner is a [redacted] who has been enrolled in the [redacted] through Respondent at various times. (Testimony of Respondent's Representative).

3. Beginning July 1, 2015, Petitioner was enrolled in the [redacted] program. (Exhibit A, pages 3-4).

4. Petitioner remained in the [redacted] program until December 31, 2015, at which point he was voluntarily disenrolled from the program. (Exhibit A, pages 3-4).

5. As of August 1, 2016, Petitioner again enrolled in the [redacted] program. (Exhibit A, pages 3-4).

6. Petitioner remained in the [redacted] program until August 31, 2016, at which point he was again voluntarily disenrolled. (Exhibit A, pages 3-4).

7. As of November 1, 2016, Petitioner again enrolled in the [redacted] program. (Exhibit A, pages 3-4).

8. Following the completion of an assessment on November 17, 2016, Petitioner was also approved for LTSS, with an effective start date of November 17, 2017. (Testimony of Respondent's Manager for the [redacted] program).

9. Petitioner remained in the [redacted] program until December 31, 2016, at which point he was again voluntarily disenrolled. (Exhibit A, pages 3-4).

10. From March 1, 2017 to March 31, 2017, Petitioner again enrolled in the [redacted] program. (Exhibit A, pages 3-4).

11. As of April 1, 2017, Petitioner was disenrolled from the program after he relocated out of his plan's service area. (Exhibit A, pages 3-4).

12. On May 8, 2017, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Petitioner and his representative regarding Respondent's alleged failure to approve and pay for LTSS.

13. That appeal was docketed by MAHS as Docket No. 17-005826 ICDE.

14. On June 7, 2017, a hearing was held in Docket No. 17-005826 ICDE before the undersigned Administrative Law Judge.

15. Following that hearing, the undersigned Administrative Law Judge issued a Decision and Order in which he reversed Respondent and ordered it to initiate a reassessment of Petitioner's request for past services and payments.

16. On November 29, 2017, MAHS received another request for hearing filed by Petitioner and his representative. (Exhibit A, page 2).

17. In that request, Petitioner and his representative asserted that Respondent had still failed to make payments for all of the services provided. (Exhibit A, page 2).

18. On January 4, 2018, a telephone pre-hearing conference was held.

19. During that conference, the representatives for the parties and the undersigned Administrative Law Judge discussed the relationship of this case to the previous case and confirmed the specific time periods for which Petitioner claims he should have been approved for LTSS, and during which such services were provided, but that Respondent never paid for the services.

20. The undersigned Administrative Law Judge also indicated that the matter would be proceed to hearing with respect to those claims.

21. On January 31, 2018, the hearing was held and completed 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.

This case involves the MI Health Link managed care program and, with respect to that program, 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.

* * *

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 and failed to pay for LTSS provided by Petitioner's representative during July of 2016; the last two weeks of September of 2016; October of 2016; and January of 2017; and February of 2017. Petitioner's representative also testified that, while Petitioner was enrolled in November of 2016, Respondent did not perform an assessment until November 16, 2017 and payments were never made for the first two weeks of November of 2016 either. Petitioner's representative further testified that Petitioner never voluntarily disenrolled and that Respondent refuses to take responsibility for their improper actions. Instead, according to Petitioner's representative, Respondent just continues to say someone else disenrolled him, just as it did during the previous hearing.

In support of its actions, Respondent's representative testified that it made the appropriate payments for services that were approved and provided, and that Petitioner was mostly disenrolled during the time periods for which he claims additional payments

should be made. She also testified that Respondent did not disenroll Petitioner and that it instead relied upon enrollment information provided by CMS.

Respondent's Manager for the MI Health Link program, also testified that, while Petitioner was enrolled in the program for the first two weeks of November of 2016, the required assessment was not completed until later that month and that, once it was, Petitioner was promptly approved for services, with an effective start date of November 17, 2017.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred by failing to make payments for LTSS.

Given the record and applicable policies in this case, Petitioner and his representative have failed to meet that burden of proof and Respondent's decision must therefore be affirmed. Petitioner's representative asserts that nothing is different in this case from the previous case, after which Respondent's actions were reversed, but that is not true as Respondent provided specific enrollment information in this case for the specific time periods in dispute. That information also expressly states that Petitioner was disenrolled for the vast majority of time for which he now seeks payment and, accordingly, services could not be approved and payments could not be made. Moreover, while Petitioner's representative asserts that the enrollment information is inaccurate because Petitioner never voluntarily disenrolled, he did not dispute that Petitioner was in fact disenrolled as identified by Respondent; Respondent's representative credibly explained that the actions were taken by the State of Michigan and its enrollment broker; and Petitioner never filed any request for hearing with respect to disenrollments at the time, as was his right.

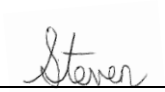
Additionally, while it is undisputed that Petitioner was enrolled in the MI Health Link program for the entirety of November of 2016, it is also undisputed that Petitioner was not reassessed and reapproved for LTSS until November 17, 2017 and Respondent therefore properly declined to make payments for the first two weeks of that month. Such a reassessment and reauthorization is necessary after Petitioner reenrolled and Petitioner's representative offered no evidence that there was any improper delay in authorizing the LTSS.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied additional payments for services.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED**.



SK/tm

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

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