

ISSUE

Did Respondent properly terminate Petitioner's PACE 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 an organization that contracts with the Michigan Department of Health and Human Services (MDHHS or Department) and oversees the PACE program in Petitioner's geographical area. (Exhibit A; Testimony)
2. Petitioner is a Medicaid beneficiary, who was enrolled in PACE through Respondent. (Exhibit A; Testimony)
3. On December 20, 2019, Respondent completed a LOCD for Petitioner. In this LOCD, Petitioner was found to be ineligible for a Michigan Medicaid nursing facility level of care based upon her failure to qualify via entry through one of the seven doors. (Exhibit A; Testimony)
4. On December 20, 2019, Respondent provided Petitioner written notice that she would be dis-enrolled from PACE due to her no longer meeting the level of care requirement for the program. (Exhibit A; Testimony)
5. On December 30, 2019, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's Request for Hearing. (Exhibit A)
6. On January 1, 2020, Petitioner traveled to REDACTED where she is currently residing. (Testimony)

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.

PACE services are available as part of the Medicaid program and, with respect to the program and its services, the Medicaid Provider Manual (MPM) provides:

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.

PACE provides an alternative to traditional nursing facility

care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize the dignity of, and respect for, older adults;
- Enable frail, older adults to live in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

The PACE capitated benefit was authorized by the Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)

SECTION 2 – SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

The PACE organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary. Services must include, but are not limited to:

- Adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work and personal care
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care
- Interdisciplinary assessment and treatment planning
- Home health care, personal care, homemaker and chore services
- Restorative therapies
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures
- Transportation for medical needs
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies
- Respite care

- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care

SECTION 3 – ELIGIBILITY AND ENROLLMENT

3.1 ELIGIBILITY REQUIREMENTS

To be eligible for PACE enrollment, applicants must meet the following requirements:

- Be age 55 years or older.
- Meet applicable Medicaid financial eligibility requirements. (Eligibility determinations will be made by the Michigan Department of Health and Human Services (MDHHS).)
- Reside in the PACE organization's service area.
- Be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.
- Receive a comprehensive assessment of participant needs by an interdisciplinary team.
- A determination of functional/medical eligibility based upon the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online within fourteen (14) calendar days from the date of enrollment into the PACE organization.
- Be provided timely and accurate information to support Informed Choice for all appropriate Medicaid options for Long Term Care.
- Not concurrently enrolled in the MI Choice program.
- Not concurrently enrolled in an HMO.

3.2 COMPLETION OF THE MEDICAID NURSING FACILITY LOC DETERMINATION

A PACE applicant's eligibility for coverage of nursing facility services and enrollment in the PACE organization is

determined by the online application of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). The PACE organization will not be reimbursed for nursing facility services rendered when the applicant is determined not to meet the LOCD criteria. Providers must submit the LOCD information into its online version no later than fourteen (14) calendar days following the start of services. Instructions and required forms related to the completion of the Medicaid Nursing Facility Level of Care Determination are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The LOCD must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider.

Nonclinical staff may perform the evaluation when clinical oversight by a professional is performed. The

PACE organization will be held responsible for enrolling only those participants who meet the criteria outlined in this section.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the online version in the following situations:

- all new enrollments of Medicaid-eligible beneficiaries.
- re-enrollment of Medicaid-eligible beneficiaries.
- significant change in condition of a current PACE Medicaid-eligible beneficiary.

The online LOCD must be completed only once for each admission or readmission to the program.

3.4 NURSING FACILITY LEVEL OF CARE EXCEPTION PROCESS - EXCEPTION REVIEW

A Nursing Facility (NF) Level of Care (LOC) Exception Process is a review that is available for financially eligible beneficiaries who have demonstrated a significant level of long term care need but do not meet the LOCD. The NF LOC Exception Process is initiated when the PACE organization telephones the MDHHS designee and requests the NF LOC Exception Review on the date that the applicant was

determined ineligible based on the online version of the LOCD. The NF LOC Exception criteria and information on how to request an Exception Review is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.5 TELEPHONE INTAKE GUIDELINES

The Telephone Intake Guidelines are questions that identify potential PACE participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the PACE organization. The guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.6 ANNUAL RECERTIFICATION

MDHHS must annually certify that PACE participants continue to meet PACE financial eligibility requirements. PACE organizations must also ensure that participants continue to meet the LOCD criteria on an ongoing basis. If the participant continues to meet the LOCD criteria, it must be demonstrated in the medical record by way of initial comprehensive assessments, reassessments and progress notes. Additional online LOCDs are not conducted for the purpose of determining ongoing LOCD eligibility.

If the PACE participant no longer meets the LOCD criteria, federal regulations may deem the participant to be eligible for the PACE program until the next annual reevaluation if, in the absence of continued coverage under PACE, the participant reasonably would be expected to again meet the nursing facility level of care criteria within the next six months.

*Medicaid Provider Manual
PACE Chapter
January 1, 2019, pp 1-4
(Emphasis added)*

A LOCD is therefore mandated for all Medicaid-reimbursed admissions to and services through PACE. Moreover, even after admission to the program, a beneficiary must also continue to meet the outlined criteria in the LOCD on an ongoing basis.

The LOCD consists of seven-service entry doors or domains. The doors are: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependency.

In order to be found eligible for Medicaid nursing facility coverage the Petitioner must have met the requirements of at least one door:

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, Respondent determined that Petitioner did not pass through any of the above seven doors during the December 20, 2019 LOCD, and that she was therefore ineligible for PACE services.

Petitioner testified that she needs the services for emotional support and that she is only in REDACTED visiting and to see if she could live out there. Petitioner indicated she enjoys the program.

Given the LOCD and the testimony during the hearing, the findings regarding the doors must be affirmed. It is undisputed that Petitioner is independent in all the tasks identified in Door 1; none of her reported conditions or behaviors meet the criteria for passing through Doors 2 or 6; and the medical treatment Petitioner was receiving did not reach the levels required by Doors 3, 4, or 5. With respect to Door 7, Respondent properly noted Petitioner does not require ongoing services to maintain her current functional status.

Respondent's decision must therefore be affirmed as a beneficiary must continue to meet the outlined criteria on an ongoing basis in order to remain in PACE and, while Petitioner previously qualified for the program and has certainly benefitted from it, it is clear that she no longer meets the applicable criteria.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent's properly terminated Petitioner's PACE services.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED**.