

ISSUE

Did Respondent properly deny Petitioner's request for hearing aids?

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 PACE in Petitioner's geographical area.
2. Petitioner is an REDACTED year-old Medicaid beneficiary who has been enrolled in PACE and receiving services through Respondent. (Exhibit F).
3. As part of her services through Respondent, Petitioner was approved for hearing aids, including replacements for ones that had been lost. (Testimony of Petitioner; Testimony of Social Worker).
4. In March of 2022, Petitioner requested another set of hearing aids to replace ones that were lost. (Testimony of Social Worker).
5. On March 23, 2022, Respondent sent Petitioner an Adequate Action Notice stating that her request for hearing aids had been denied. (Exhibit C).
6. With respect to the reason for the action, the notice stated: **"IDT Denied this request due to participant receiving replacement hearing aids from Huron Valley Pace in July 2021."** (Exhibit C).
7. On May 23, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the Request for Hearing filed by Petitioner in this matter regarding the Respondent's decision. (Exhibit A).

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 eligibility for it, the Medicaid Provider Manual (MPM) provides:

SECTION 1 - GENERAL INFORMATION

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 federal 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 ...

*MPM, January 1, 2022 version
PACE Chapter, pages 1-2
(Emphasis added)*

Here, Respondent denied Petitioner's request for replacement hearing aids on the basis that she had already recently received replacement hearing aids. During the telephone hearing, Respondent's representative also cited to Medicaid policy providing that hearing aids are only a benefit when the beneficiary has not received a Medicaid covered hearing aid within the last five years.

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 the 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 met that burden of proof and Respondent's decision must therefore be reversed.

The denial in this case was not based on medical necessity and, instead, solely on Medicaid policy limiting coverage of hearing aids to once every five years. And, while such a policy does exist¹, it does not apply in this case. The above policies expressly provide that PACE organizations must provide all needed services and that coverage through PACE is not limited to those services reimbursable through Medicare or Medicaid, with the PACE organization assuming full financial risk for beneficiary care without limits on amount, duration, or scope of services. Accordingly, by basing its decision on Medicaid coverage limitations, Respondent erred, and its decision must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent improperly denied Petitioner's request for hearing aids.

IT IS THEREFORE ORDERED that:

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