

## **ISSUE**

Did Respondent properly deny Petitioner's request for placement at an out-of-network facility?

## **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 has been enrolled as a participant with Respondent since REDACTED, 2021. (Testimony of Respondent's representative).
3. In REDACTED of 2022, Petitioner was hospitalized, and it was determined that

- she required placement in a facility following discharge. (Testimony of Respondent's representative).
4. Petitioner was then placed at Douglas Cove, a provider within Respondent's network of providers. (Testimony of Respondent's representative).
  5. All of Petitioner's needs are being met at Douglas Cove. (Testimony of Petitioner's representative).
  6. While Petitioner's needs are met at Douglas Cove, her representative requested that she be moved to a different, out-of-network facility as Petitioner's family or friends must travel one hour each way to get to Douglas Cove. (Testimony of Petitioner's representatives).
  7. Respondent denied that request on the basis that Petitioner's needs could be accommodated within Respondent's contracted facilities. (Testimony of Respondent's representative).
  8. On November 15, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the Request for Hearing filed by Petitioner in this matter regarding Respondent's decision to deny the request for an out-of-network placement. (Exhibit #1, pages 1-10).

## **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, July 1, 2022, version  
PACE Chapter, pages 1-2  
(Emphasis added)*

Moreover, regarding the initial process of becoming a PACE organization, the MPM also provides in part:

#### **SECTION 4 - PACE ORGANIZATION EVALUATION CRITERIA**

##### **4.1 INITIAL APPLICATIONS**

A prospective PACE organization can be a not-for-profit or for profit private or public entity that is primarily engaged in providing PACE services and participates in both Medicare and Medicaid. Michigan licensure as a health care entity is not required; however, unlicensed entities may only serve Medicare and Medicaid beneficiaries. Federal regulations (42 CFR Part 460) describe administrative requirements for PACE. **At a minimum, prospective entities must meet the federal requirements for PACE organizations, enroll as a**

Michigan Medicaid provider, and complete a feasibility study. MDHHS will evaluate potential PACE organizations using the following criteria:

- Submission of a feasibility study that:
  - identifies the proposed service area;
  - shows evidence of demand for PACE services in the proposed service area (the potential pool of PACE beneficiaries should be sufficient to have 250 to 300 beneficiaries enrolled within four to five years of start-up);
  - identifies competing PACE organizations, documents the organization's timeline for development and anticipated costs;
  - identifies the anticipated source of referrals for potential beneficiaries; and
  - assesses the supply of alternative long-term care services already in existence in the community.

If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which they are received.

- Organizational commitment to principles consistent with the PACE model.
- Evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support.
- Evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully.
- Evidence that the PACE organization will either be cost neutral or save money for long term care services provided by MDHHS in the PACE organization's service area (i.e., total Medicaid expenditures for services in the service area will not increase and may decrease).

- Assurance of adequate financial capacity to fund program development and start-up costs, including identification of patient capacity and break-even consideration.
- Evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population.
- Evidence that the Executive (Program) Director position will be staffed with a full-time employee.
- Evidence that the key positions of Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed, as determined by MDHHS, to meet the needs of the PACE organization.
- Ability to meet federal PACE requirements.

A prospective PACE program must submit to MDHHS:

- Feasibility Study: within 90 calendar days of submitting their letter of intent.
- Provider Application: within one year of MDHHS approval of the feasibility study.

Other evaluation criteria may be considered and will be available to organizations who file a letter of intent with MDHHS to become a PACE organization.

*MPM, July 1, 2022, version  
PACE Chapter, pages 9-10  
(Emphasis added)*

Here, Respondent denied Petitioner's request for placement at an out-of-network facility pursuant to the above policies.

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 not met that burden of proof and Respondent's decision must therefore be affirmed.

Petitioner seeks placement at a facility outside of Respondent's network of providers, but Respondent is required to have a network of providers and permitted to generally limit the provision of services to providers within its network.

Moreover, while Respondent might be required to go outside of its network if it is medically necessary, it is undisputed that it is not necessary in this case as Petitioner's needs are being met at a facility within Respondent's network. It may be more convenient or even better for Petitioner to be at a different facility closer to her family, but it is not medically necessary.

Additionally, while Petitioner's representative asserts that Respondent needs to expand its provider network as a general matter to better serve Petitioner and other participants, that is not an appealable issue. Petitioner's representative is free to file a grievance regarding his request.

Accordingly, given that Petitioner's needs are being met in her current, in-network placement, Respondent's decision to deny a request for an out-of-network placement must be affirmed.

### **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 placement at an out-of-network facility.

**IT IS THEREFORE ORDERED** that:

Respondent's decision is **AFFIRMED**.