

ISSUE

Did Respondent properly deny Petitioner's request for reimbursement for an outside medical appointment through the Program of All-Inclusive Care for the Elderly (PACE)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. PACE 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 an adult female who has been receiving services through PACE. (Exhibit A; Testimony).
3. On January 13, 2023, PACE received a request from Petitioner's daughter for reimbursement for an outside medical appointment attended by Petitioner on REDACTED 2023. (Exhibit B; Testimony)

4. On January 13, 2023, PACE sent Petitioner an Adequate Action Notice Denial of Service informing Petitioner that her request for reimbursement for an outside medical appointment was denied. The notice indicated, in pertinent part: "IDT denied this request due to Huron Valley PACE providing same services to all patients enrolled at PACE and patient did not have authorization for appointment." (Exhibit B; Testimony)
5. On February 27, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A).

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.

PACE services are available as part of the Medicaid program:

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

3.13 APPLICANT APPEALS

3.13.C. PACE SERVICES

Noncoverage or nonpayment of services by the PACE organization for a beneficiary enrolled in PACE is an adverse action. If the beneficiary and/or representative disagrees with the noncoverage or nonpayment of services by the PACE organization, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MOAHR website. (Refer to the Directory Appendix for website information.) The beneficiary may request continuation of the disputed service with the understanding that he may be liable for the cost of the disputed service if the determination is not made in his favor.

*Medicaid Provider Manual
Program of All-Inclusive Care for the Elderly Chapter
October 1, 2022, pp 1-2, 7*

With regard to medical necessity, the Medicaid Provider Manual indicates:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
 - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
 - that are experimental or investigational in nature; or
 - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services; and/or
- Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services,

concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

*Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
October 1, 2022, pp 13-14*

The PACE Enrollment Agreement Petitioner and her daughter signed upon August 24, 2022 provides, in relevant part:

6. Accessing Services

- When you are Huron Valley PACE participant, all of your health care services will be provided only through Huron Valley PACE with the exception of emergency care.
- Members of your Personal Care Team must approve all health care services with the exception of emergency care.

Important Notice

When you became a participant, you are agreeing to accept benefits ONLY from Huron Valley PACE in place of your usual Medicare and Medicaid benefits.

Lock-In Provision

You may be fully liable for the costs of medical services from an out-of-network provider or without prior authorization (with the exception of emergency services).

Exhibit F
Emphasis in original

PACE's Center Director testified that Petitioner was denied reimbursement for the outside medical appointment attended on REDACTED 2023 because PACE offers the same services, and the outside appointment was not pre-authorized. PACE's Center Director also noted that the progress note from the doctor's office on REDACTED 2023 indicates that Petitioner and her daughter were aware that the appointment was not approved by PACE. PACE's Center Director testified that the doctor's office even called PACE and were informed that the appointment had not been approved.

Petitioner's daughter testified that her mother has been with PACE since 2021 and through the course of her care, PACE has removed from Petitioner's MI Health account any appointments that were not approved. Petitioner's daughter indicated that this appointment appeared in Petitioner's MI Health account, and she received both a telephone and text reminder for the appointment so she assumed that it had been approved by PACE. Petitioner's daughter testified that Petitioner's eye appointments are also done outside of PACE, so she figured this was something like that. Petitioner's daughter testified that it takes Petitioner a very long time to get ready to leave the house, about one to two hours, so when they got to the appointment they decided to go ahead. Petitioner's daughter indicated that Petitioner's mother had been suffering from diarrhea for a long-time and she was hoping getting another opinion might help her. Petitioner's daughter also indicated that when she contacted PACE from the doctor's office, the receptionist informed her that the appointment might be covered if the IDT deemed it necessary. Petitioner's daughter testified that they already have a lot of medical bills for her mother and would appreciate any help in covering this bill.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her request for reimbursement for an outside medical appointment. Based on the above evidence presented, this Administrative Law Judge (ALJ) finds that Petitioner has failed to meet this burden of proof. As the above policy from the Medicaid Provider Manual indicates, "The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization." In addition, the agreement signed by Petitioner and her daughter with Huron Valley PACE indicates, "When you are [a] Huron Valley PACE participant, all of your health care services will be provided only through Huron Valley PACE with the exception of emergency care. Members of your Personal Care Team must approve all health care services with the exception of emergency care." The agreement also indicates, "When you became a participant, you are agreeing to accept benefits ONLY from Huron Valley PACE in place of your usual Medicare and Medicaid benefits. You may be fully liable for the costs of medical services from an out-of-network provider or without prior authorization (with the exception of emergency services)."

Here, the appointment on REDACTED 2023 was not pre-authorized by PACE and the appointment was not an emergency. In addition, Petitioner and her daughter were informed at the doctor's office that PACE had not authorized the appointment, but they decided to go ahead anyway in the hope that PACE would approve the appointment after the fact. While that decision was understandable given Petitioner's medical

condition, this ALJ simply has no authority to ignore clear policy or to provide any equitable relief.

Accordingly, this ALJ finds that Petitioner has failed to prove, by a preponderance of the evidence, that Respondent's denial was improper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that Respondent properly denied Petitioner's request for reimbursement for an outside medical appointment.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **AFFIRMED**.