



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

[REDACTED]
[REDACTED] MI [REDACTED]

Date Mailed: June 26, 2023
MOAHR Docket No.: 23-002753
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq.* and 42 CFR 438.400 *et seq.* upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 22, 2023. [REDACTED] Petitioner's Daughter, appeared on behalf of Petitioner.

Florence Scott-Emuakpor of Health and Human Services (Department or MDHHS), Darleen Murphy-Anderson, LOCD Policy Specialist; Kathy Nance, R.N.; and Janit Risbon, Clinical Care Coordinator, appeared as witnesses for the Department/Waiver Agency.

ISSUE

Did the Department properly determine that Petitioner does not require a Medicaid reimbursable Nursing Facility (NF) Level of Care (LOC)?

FINDINGS OF FACT

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

1. On [REDACTED] 2023, Gladwin Pines conducted an online LOCD for Petitioner. (Exhibit A.)
2. Following the LOCD, Gladwin Pines determined Petitioner was not eligible for services. (Exhibit A.)
3. Following the determination, Petitioner timely requested a secondary review. (Exhibit A.)

4. Gladwin Pines did not provide iMPROve Health (MPRO) with the appropriate documentation to timely perform the secondary review. (Exhibit A.)
5. On May 16, 2023, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A.)
6. On June 22, 2023, a hearing was commenced regarding Petitioner's request for hearing. During the hearing, all parties agreed this matter should be reversed and that Gladwin Pines should perform a new LOCD. (Testimony.)

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.

The Michigan Department of Health and Human Services (MDHHS) implemented functional/ medical eligibility criteria for Medicaid nursing facilities. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria.

The Medicaid Provider Manual (MPM) articulates Medicaid policy in Michigan. With regard to nursing facility eligibility, the MPM provides, in pertinent part:

SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) is required to assess all individuals seeking Medicaid-funded long-term services and supports (LTSS) to determine their functional need for those services. The determination is an essential component of eligibility for services in nursing facilities, the MI Choice Waiver Program, the Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link HCBS Waiver Program. Policies contained herein apply equally and consistently to each of these programs except as noted.

SECTION 2 – ELIGIBILITY REQUIREMENTS

Individuals seeking Medicaid-funded services from nursing facilities, MI Choice Waiver Program, PACE, or the MI Health Link HCBS Waiver Program must meet eligibility

criteria. These criteria must be met before Medicaid payment is made for services rendered. Each beneficiary must be eligible for Medicaid services, demonstrate a need for nursing facility level of care, and meet all additional program-specific requirements. Medicaid reimbursement for covered services is only appropriate when both financial and functional eligibility have been established, and the individual meets other program-specific eligibility criteria.

2.1 BASIC MEDICAID ELIGIBILITY

Eligibility for Medicaid is determined by a variety of factors including, but not limited to, financial rules, age, health status, state residency and citizenship status. Providers are instructed to refer individuals who are not yet Medicaid eligible to a local MDHHS office or the MDHHS website for assistance. (Refer to the Directory Appendix for website information.)

2.2 NEED FOR NURSING FACILITY LEVEL OF CARE

An individual's need for nursing facility level of care is determined through the Nursing Facility Level of Care Determination (LOCD) assessment tool. The LOCD is a scientifically-validated and reliability-tested tool utilized during initial application and program eligibility redeterminations. This chapter describes the criteria and processes for administering the LOCD.

2.3 PROGRAM SPECIFIED ELIGIBILITY REQUIREMENTS

In addition to meeting Medicaid financial and functional eligibility requirements, individuals must also meet all program specific requirements before they can be determined eligible for that program. (Refer to the Nursing Facility Coverages, the MI Choice Waiver, the Program of All-Inclusive Care for the Elderly, and the MI Health Link chapters or to provider contracts for specific program requirements.) This chapter applies only to the LOCD process and is not intended to replace program-specific requirements.

The MPM also lists the policy for admission and continued eligibility processes for Medicaid-reimbursed nursing facilities. This process includes a subsequent or additional web-based LOCD upon determination of a significant change in the

beneficiary's condition as noted in provider notes or minimum data sets and that these changes may affect the beneficiary's current medical/functional eligibility status.

The LOCD is required for all Medicaid-reimbursed admissions to nursing facilities. A subsequent LOCD must be completed when there has been a significant change in condition that may affect the NF resident's current medical/functional eligibility status.

The Michigan Medicaid Nursing Facility LOC Determination's medical/functional criteria include eight domains of need:

- Activities of Daily Living
- Cognitive Performance
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitative Therapies
- Behavior,
- Service Dependency, and
- Frailty

If the provider determines through the LOCD that an individual is no longer eligible for nursing facility level of care paid for by Medicaid, the individual may request a secondary review.

6.4 LOCD SECONDARY REVIEW

The provider or the individual (or their legal representative) may request an LOCD Secondary Review. This review is completed by MDHHS or its designee to ensure full consideration of LOCD eligibility options. The Secondary Review is available only when an LOCD is entered in CHAMPS and results in a Door 0, indicating ineligibility. The review is a secondary review of documentation for all LOCD Doors, including Door 8.

Individual residents or their authorized representatives are allowed to appeal either a determination of financial ineligibility to the Department of Health and Human Services or medical/functional eligibility to the Department of Health and Human Services:

6.5 APPEAL RIGHTS AND MEDICAID FAIR HEARING

When an individual is determined ineligible for services and an appeal is requested, it is an adverse action for the individual. If the individual or their legal representative disagrees with the denial, they may request an administrative hearing.

The Michigan Office of Administrative Hearings and Rules (MOAHR), Administrative Hearings Pamphlet explains the process by which an administrative hearing and a preliminary conference are brought to completion. The pamphlet is available for review on the MDHHS website. (Refer to the Directory Appendix for website information.) Both a provider representative and a MDHHS Long Term Care Policy Section representative must be present at the hearing.

When a beneficiary is determined to no longer be eligible for Medicaid-funded services and an appeal is requested, Medicaid will continue to pay for services if the beneficiary appeals within required program timeframes. If the beneficiary does not appeal the decision, the provider is eligible for Medicaid-reimbursement through the effective date of the advanced action notice, or the date in which the beneficiary stopped receiving services, whichever is first. When the beneficiary appeals the decision in compliance with MDHHS policy, MDHHS will reimburse the provider for services throughout the appeal process. If the beneficiary's appeal is denied, MDHHS will reimburse the provider for up to 30 days from the date of issuance of the hearing decision and order.¹

In the present case, the parties all agreed the Petitioner should have been afforded a secondary review following the initial decision to deny services. It was also agreed that in this case, the secondary review was not completed due to an issue with the facility failing to provide the appropriate documentation. To resolve this issue, the parties agreed to the facility performing a new NFLOC determination.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Department incorrectly determined that Petitioner did not require a Medicaid Nursing Facility Level of Care.

¹ Medicaid Provider Manual, Nursing Facility Level of Care Determination Chapter, April 1, 2023, pp 1-14.

IT IS THEREFORE ORDERED that:

The Department's decision is **REVERSED**.

The Department must initiate the performance of a new NFLOC determination.

CA/pe



Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Via Electronic Mail:

DHHS Department Contact

Emily Frankman
MDHHS
Lansing, MI 48933
FrankmanE@michigan.gov

Agency Representative

Florence Scott-Emuakpor, MDHHS
Appeals Review Officer
Lansing, MI 48909
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DHHS Department Representative

M. Carrier
Department Community Health
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Lansing, MI 48909
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Via First Class Mail:

Authorized Hearing Representative

[REDACTED]
[REDACTED] MI [REDACTED]

Community Health Representative

Gladwin Pines
449 Quarter Street
Gladwin, MI 48624

Petitioner

[REDACTED]
[REDACTED] MI [REDACTED]