

ISSUE

Did Respondent properly deny Petitioner's request for enrollment in 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. Respondent is an organization that contracts with the Michigan Department of Health and Human Services (MDHHS) and oversees PACE in Petitioner's geographical area.
2. In REDACTED of 2023, Petitioner applied for services through PACE, and, on June 14, 2023, an assessment was performed with Petitioner and her representative. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

3. On June 15, 2023, Respondent sent Petitioner written notice that her request for enrollment in PACE had been denied. (Exhibit A, pages 1-2).
4. With respect to the reason for its decision, Respondent stated that Petitioner did not meet the required nursing facility level of care. (Exhibit A, page 1).
5. On June 27, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the Request for Hearing in this matter with respect to that denial. (Exhibit #1, pages 1-3).

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 in general and eligibility for it specifically, the Medicaid Provider Manual (MPM) in place at the time of the decision in this case provided:

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.)

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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.

*MPM, April 1, 2023, version
PACE Chapter, pages 1-2*

Moreover, regarding the required determination of functional/medical eligibility based upon LOCD, the MPM further provides:

SECTION 4 - NURSING FACILITY LEVEL OF CARE DETERMINATION CRITERIA

The Michigan Nursing Facility Level of Care Determination criteria includes seven domains of need, called Doors. The Doors include: (1) Activities of Daily Living; (2) Cognitive Performance; (3) Physician Involvement; (4) Treatments and Conditions; (5) Skilled Rehabilitation Therapies; (6) Behaviors; and (7) Service Dependency. The Doors and the assessment items are listed below. Guidance on administering the LOCD, including definitions and methods, is provided in the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines.

The LOCD should be an accurate reflection of an individual's current functional status. This information is gathered in a face-to-face meeting by speaking to the individual and those who know the individual well, observing the individual's

activities, and reviewing an individual's medical documentation. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines on the MDHHS website for more information. (Refer to the Directory Appendix for website information.)

4.1 DOOR 1: ACTIVITIES OF DAILY LIVING

Door 1 assesses four ADLs: (1) Bed Mobility; (2) Transfers; (3) Toilet Use; and (4) Eating.

4.2 DOOR 2: COGNITIVE PERFORMANCE

Door 2 assesses short-term memory, cognitive skills for daily decision-making and making self-understood.

4.3 DOOR 3: PHYSICIAN INVOLVEMENT

Door 3 assesses the frequency of physician visits and physician order changes.

4.4 DOOR 4: TREATMENTS AND CONDITIONS

Door 4 assesses a set of nine treatments and conditions that may be a predictor of potential frailty or increased health risk. The treatments and conditions include: Stage 3-4 Pressure Sores; Intravenous or Parenteral Feeding; **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 the Last 14 Days; and Peritoneal or Hemodialysis.

4.5 DOOR 5: SKILLED REHABILITATION THERAPIES

Door 5 assesses the presence of rehabilitation interventions, including physical therapy, occupational therapy, and speech therapy.

4.6 DOOR 6: BEHAVIOR

Door 6 assesses behavioral challenges. It includes five behavioral symptoms: wandering, verbal abuse, physical abuse, socially inappropriate or disruptive behavior, and resistance to care. Door 6 also assesses for the presence of delusions and hallucinations.

4.7 DOOR 7: SERVICE DEPENDENCY

Door 7 applies to beneficiaries currently receiving other services and supports in nursing facilities, MI Choice, PACE, or the MI Health Link HCBS Waiver program. It assesses the beneficiary's dependence on services to maintain the current level of functioning and whether there are options for maintaining the level of functioning with services and supports available in the community.

4.8 DOOR 8: FRAILITY

MDHHS or its designee determined that the beneficiary is eligible for Medicaid LTSS services based upon the Frailty Criteria. Individuals who exhibit certain behaviors and treatment characteristics that indicate frailty may be admitted or enrolled to LTSS programs requiring an LOCD. The individual needs to trigger one element of this criteria to be considered for Frailty. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Exception Process on the MDHHS website for more information. (Refer to the Directory Appendix for website information.) For the MI Health Link program, the Frailty Criteria are applied by the Integrated Care Organization.

4.9 DOOR 0: INELIGIBLE

The LOCD was conducted and the beneficiary did not meet the criteria for any of the doors. The beneficiary is not eligible for Medicaid LTSS services at this time. (Refer to the Individual Does Not Meet LOCD Criteria, Action Notices, and Appeal Rights section for additional information.)

4.10 DOOR 87: ELIGIBLE PENDING FACE-TO-FACE REASSESSMENT

The passive redetermination process could not confirm eligibility. The provider has 45 days from the date of the passive redetermination or until the current End Date, whichever is earlier, to conduct a new face-to-face assessment.

Here, as discussed above, Respondent denied Petitioner's request for enrollment in PACE pursuant to the above policies and on the basis that Petitioner did not meet the criteria for the program identified in the LOCD assessment tool.

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 failed to meet that burden of proof and Respondent's decision must therefore be affirmed.

Petitioner's witnesses testified extensively regarding Petitioner's needs during the hearing and their testimony is essentially uncontradicted, with Respondent's representative having no personal knowledge of Petitioner's needs and the person who completed the LOCD not present for the hearing.

However, even while that uncontradicted testimony also suggested, at times, that Petitioner might pass through one or more doors of the LOCD, Petitioner has still failed to meet her burden of proof.

As discussed above, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made, and, here, Petitioner has not shown that sufficient information was provided to find that Petitioner met the LOCD criteria.

Only Petitioner's representative was a witness who was also present during the evaluation at issue and her testimony was inconsistent as to what was reported during the LOCD, with Petitioner's representative also acknowledging that she has a poor memory and that Petitioner has worsened at times, with the testimony unclear as to whether Petitioner's representative was describing Petitioner's condition at the time of the LOCD or her current condition.

During the hearing, the parties did agree to have a new LOCD completed and, to the extent Petitioner has additional or updated information to provide regarding her need for services, she and her representative can always have a new request submitted in the future. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

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 enrollment.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.