ISSUE

Did Respondent properly deny Petitioner's request to transfer from a skilled nursing facility (SNF) to her home while on a ventilator?

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 a Medicaid beneficiary who has been receiving services through PACE and has been diagnosed with numerous health conditions, including acute respiratory failure and chronic obstructive pulmonary disease. (Exhibit A, p 17; Testimony)

3. In approximately June 2023, Petitioner's spouse requested that Petitioner be transferred from a SNF to her home while on a ventilator. (Exhibit A, p 28; Testimony)

4. On June 13, 2023, following an in-person assessment of Petitioner and a review by PACE's Interdisciplinary Team (IDT), Petitioner and her spouse were informed that the request for a transfer home while on a ventilator was denied. (Exhibit A, pp 28-29, 40-42; Testimony.) Specifically, PACE staff informed Petitioner and her spouse that the request was denied for not meeting the guidelines for such a transfer, including:

   - The participant does not have readily available and competently trained family members, accessible entrances, and back-up electrical systems.
   - The participant does not have two competently trained back-up family members or caretakers (in addition to the trained staff provided by PACE) that are required and adequate respite care for the primary family members.
   - All family members living with patient and back-up family members or caretakers have not received basic life support instruction.
   - The home is not a safe and sanitary environment with no fire, health, or safety hazards. The home does not have the appropriate infrastructure.

   (Exhibit A, p 29; Testimony)

5. On June 15, 2023, PACE sent Petitioner and her spouse a Denial of Service, indicating that the request for a transfer to her home while on a ventilator had been denied based on the assessment. (Exhibit A, pp 3-11; Testimony)

6. On June 29, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's Request for Hearing. (Exhibit A, pp 35-36)

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 its services, the Medicaid Provider Manual (MPM) provides:

> 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
- 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

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.

Medicaid Provider
Manual PACE Chapter
April 1, 2023, pp 1-3
Emphasis added

PACE's clinical guidelines for at home care for patients on a ventilator indicate:

- Mechanical ventilation should be considered for use in the home only if the proper resources are available, such as readily available and competently trained family members, (in addition to the trained staff provided by PACE), accessible entrances, and back-up electrical and oxygen systems.
- Two competently trained back-up family members or caretakers (in addition to the trained staff provided by PACE) are required and adequate respite care for the primary family members must be considered.
- All family members living with patient and back-up family members or caretakers should receive basic life support instruction including tracheostomy use and care.
- The home should provide a safe and sanitary physical environment with no fire, health, or safety hazards. The home should have air-conditioning, heat, and adequate amperage with grounded outlets.
- Consideration should be made for patients who live in rural communities. A second ventilator should be considered for patients who are unable to maintain spontaneous ventilation or who live in an area where a replacement ventilator cannot be provided promptly.

(Exhibit A, pp 28-29.)

Here, Petitioner requested to be transferred from a SNF to her home while on a ventilator.

Respondent's Medical Director testified that Petitioner was assessed for in-home ventilator management, but the request was denied for numerous reasons. Respondent's Medical Director indicated that she has met with Petitioner several times in the past few months, and she continues to need significant pressure support on a ventilator. Respondent's Medical Director testified that Petitioner has had little to no weaning since she has been in the SNF, making her dependent on the ventilator and

unlikely to ever be off it. Respondent's Medical Director noted that Petitioner has also had some difficulties lately with two recent hospitalizations for infections.

Respondent's Medical Director testified that Petitioner's home does not meet the clinical requirements for ventilation management. Respondent's Medical Director noted that the home lacked a generator, a separate electrical breaker for the ventilator, back-up family members for care and respite, and a clean and safe environment. Respondent's Medical Director testified that Petitioner needs dedicated 24-hour respite and nursing staffing which she could not get at home. Respondent's Medical Director indicated that her greatest areas of concern are Petitioner's increasingly complicated medical needs in addition to her home not having the infrastructure to support a ventilator, even if back-up family members were available, which they are not.

Respondent's Associate Director testified that he has been a respiratory therapist for 20 years and evaluated Petitioner at the SNF. Respondent's Associate Director indicated that he has not seen much improvement with Petitioner's condition since arriving at the SNF. Respondent's Associate Director noted that Petitioner requires a level 28 of pressure support, which is quite high. Respondent's Associate Director indicated that the average person requires 0 pressure support and a more normal level for someone with Petitioner's conditions would be in the single digits. Respondent's Associate Director testified that if Petitioner's ventilator popped out while she was at home, she would need immediate emergency lifesaving procedures or she would die.

Petitioner's spouse testified that he and Petitioner went to PACE because she would be able to stay in her own home. Petitioner's spouse indicated that Petitioner is doing better and wants to come home. Petitioner's spouse noted that he was living on Petitioner's social security and now has no way to survive, or keep the home, with Petitioner living in a SNF. Petitioner's spouse testified that Petitioner is being held against her wishes. Petitioner's spouse testified that they live in a trailer home, and they have had APS come out before and they never removed Petitioner because of the condition of the home.

Petitioner's spouse testified that taking care of Petitioner was his livelihood and she is not getting 24/7 care in the SNF. Petitioner's spouse indicated that he has pressed Petitioner's call light and it usually takes staff 45 minutes to an hour to respond. Petitioner's spouse admitted that he has gotten angry at PACE staff, but he gets angry when he does not get what he needs. Petitioner's spouse indicated that he was told that he cannot be trained on the ventilator in the SNF because the ventilator at home would be different. Petitioner's spouse testified that he does have a generator at home, but it is not automatic; he must go outside and start it. Petitioner's spouse indicated that he would be willing to get a home generator if Petitioner was allowed to come home.

In response, PACE's Associate Director indicated that while ventilators can be different, the ventilator in the SNF would be very similar to the type used for homecare.

Petitioner's therapist testified that Petitioner loves his wife and wants her home, and she wants to be home. Petitioner's therapist indicated that is why they enrolled in PACE to

begin with. Petitioner's spouse's therapist noted that Petitioner's spouse is under a lot of stress with the current situation, and he believes he would be able to take care of her at home. Petitioner's spouse's therapist testified that Petitioner's spouse does get upset but he is not violent at all; that's just how he expresses himself. Petitioner's spouse's therapist indicated that Petitioner's spouse feels like he is being disregarded by PACE because he cannot read or write.

In response, PACE's Medical Director testified that she has personally witnessed Petitioner being violent with his words, e.g., making threats to staff while mentioning firearms, and noted that the SNF recently had to call the police on him.

Given the above findings of fact and applicable policies, the undersigned Administrative Law Judge finds that Respondent PACE properly denied Petitioner's request.

As indicated above, there are certain criteria and requirements that must be met before someone can be sent home on a ventilator. Included in these requirements are a backup power supply, two competent and trained backup family members or caretakers, and training in basic life support. Here, at the time the decision in this matter was made, Petitioner failed to meet any of these criteria. Having heard all the evidence, it is clear to this All that Petitioner's spouse simply fails to appreciate how sick Petitioner is and how much care she would require at home. And, while Petitioner's spouse has cared for Petitioner at home before, her condition is much worse now than at that time. Of course, it is understandable that Petitioner's spouse wants Petitioner home, and Petitioner's spouse should be commended on all the care that he has provided, and continues to provide, to Petitioner. However, at this time it would not be safe for Petitioner to be sent home from the SNF on a ventilator. Should Petitioner's condition improve, another request to transfer home can be considered. If that were to occur, Petitioner's spouse would also need to ensure that all the other criteria discussed above are met.

Therefore, based on the evidence presented, PACE's decision should be upheld.

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 to transfer from a SNF to her home while on a ventilator.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**