



GRETCHEN WHITMER
GOVERNOR

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

MARLON I. BROWN, DPA
ACTING DIRECTOR

[REDACTED]
MI [REDACTED]

Date Mailed: November 22, 2023
MOAHR Docket No.: 23-005574
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on October 12, 2023. [REDACTED] Petitioner's brother/legal guardian, appeared and testified on Petitioner's behalf. Florence Scott-Emuakpor, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Ian Lowers, a Departmental Analyst with the Department; Lisa Vandermeer, an MDS Coordinator at Mission Point Nursing & Psychical Rehabilitation of Forest Hills ("Mission Point"); and Emily Alt, a social worker at Mission Point; testified as witnesses for the Department.

During the hearing, the Department submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-71. No other proposed exhibits were submitted.

Following the hearing, the record was left open until November 2, 2023, so that Petitioner could file a written response to the Department's evidence and the Department could file a reply to Petitioner's response.

Petitioner timely filed a response; no reply was received from the Department; and the record closed as scheduled on November 2, 2023.

ISSUE

Did the Department properly determine that Petitioner does not qualify for a nursing facility level of care?

FINDINGS OF FACT

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

1. Petitioner is a [REDACTED] year-old Medicaid beneficiary who has a legal guardian and who has been diagnosed with, among other conditions, schizophrenia; depression; attention deficit hyperactivity disorder; a cerebral vascular accident; dysphagia; a left hip/thigh abscess; deep vein thrombosis; pneumonia; anemia; and a seizure disorder. (Exhibit A, pages 12-13; Testimony of Petitioner's representative).
2. In 2003, Petitioner was admitted as a resident at [REDACTED] a nursing care facility. (Testimony of MDS Coordinator).
3. On January 20, 2023, nursing facility staff conducted a Michigan Medicaid Nursing Facility Level of Care Determination ("LOCD") with respect to Petitioner. (Exhibit A, pages 29-35).
4. In that LOCD, Petitioner was found to be eligible for a Medicaid nursing facility level of care by passing through Door 3 of that tool. (Exhibit A, page 29).
5. On July 18, 2023, nursing facility staff conducted another LOCD with respect to Petitioner. (Exhibit A, pages 37-44).
6. In the LOCD, Petitioner was found to be ineligible for Medicaid nursing facility care based upon his failure to qualify via entry through one of the seven doors of that tool. (Exhibit A, pages 37-45).
7. On July 19, 2023, Mission Point sent Petitioner and his guardian an Advance Action Notice stating that, based upon the July 18, 2023, LOCD, it has been determined that Petitioner no longer met the functional eligibility requirement for Medicaid long-term care services. (Exhibit A, page 46).
8. The notice also provided that Petitioner could request a secondary review with iMPROve Health within the three days following receipt of the notice and/or a Medicaid Fair Hearing within ninety calendar days of the date on the notice. (Exhibit A, page 46).
9. Petitioner's guardian did not request a secondary review within the three days following his receipt of the Advance Action Notice. (Testimony of Petitioner's representative).

10. On September 11, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner's guardian in this matter. (Exhibit A, pages 1-13).

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.

The Medicaid Provider Manual (MPM), Nursing Facilities Coverages Chapter, describes the policy for admission and continued eligibility for Medicaid-reimbursed nursing facility services:

5.1 NURSING FACILITY ELIGIBILITY

There are five components that determine beneficiary eligibility and Medicaid nursing facility reimbursement.

- Verification of financial Medicaid eligibility
- PASARR Level I screening
- Physician-written order for nursing facility services
- A determination of medical/functional eligibility based upon a web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) prior to or the day of admission to a nursing facility. (Refer to the Nursing Facility Level of Care Determination Chapter for additional information.)
- Computer-generated Freedom of Choice (FOC) form signed and dated by the beneficiary or the beneficiary's representative as described in the Nursing Facility Level of Care Determination Chapter.

*MPM, July 1, 2023 version
Nursing Facility Coverages Chapter
Page 7
(Internal highlighting omitted)*

Moreover, regarding the required LOCD referenced in the above policy, the MPM also states in part:

SECTION 1 – GENERAL INFORMATION [CHANGE MADE 7/1/23]

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

MDHHS uses a standard assessment and process for all programs and services that require an individual meet the nursing facility level of care. Programs may not use any other assessment in place of the Level of Care Determination (LOCD) tool for this determination. The LOCD assures a consistent and reliable process for determining that individuals meet the functional eligibility requirements.

Providers may access the LOCD online in the Community Health Automated Medicaid Processing System (CHAMPS) through the MILogin application. (Refer to the Directory Appendix for website information.) LOCD assessment data is entered and processed in CHAMPS.

The LOCD is a “point in time” assessment; that is, it determines the individual’s functional eligibility at the time of the assessment. MDHHS assumes that beneficiaries will maintain functional eligibility until they are determined otherwise through a reassessment or the LOCD’s End Date. An LOCD is an in-person meeting between the qualified and licensed health professional and the individual seeking functional eligibility. **(revised per bulletin MMP 23-20)**

* * *

SECTION 3 – NURSING FACILITY LEVEL OF CARE DETERMINATION PROCESS

3.1 LOCD ASSESSMENT REQUIREMENT FOR REIMBURSEMENT [CHANGE MADE 7/1/23]

The LOCD must be conducted prior to or on the day of an individual's admission to a nursing facility or enrollment in MI Choice Waiver Program, PACE, or MI Health Link HCBS Waiver Program to ensure reimbursement for a Medicaid eligible beneficiary. The LOCD must be conducted in person (**revised per bulletin MMP 23-20**) by a qualified and licensed health professional. The qualified and licensed health professional conducting the LOCD or a designated employee of the organization must enter the assessment findings online in the CHAMPS system. Except where otherwise noted, only LOCDs entered in CHAMPS are considered valid for establishing functional eligibility.

The LOCD is considered payable when all the following conditions are met:

- the beneficiary meets LOCD criteria;
- the LOCD is entered online in CHAMPS;
- the LOCD is active on the date of service (meaning the date of service is on or after the LOCD Start Date and before the LOCD End Date); and
- the beneficiary is receiving LTSS and meets all program-specific eligibility criteria.

3.2 PERSONS AUTHORIZED TO CONDUCT THE LOCD

A qualified and licensed health professional must be a physician, registered nurse, licensed practical nurse, licensed social worker (Limited License Bachelor of Social Work, Limited License Master Social Worker, Licensed Bachelor Social Worker, or Licensed Master Social Worker), physician's assistant, nurse practitioner, licensed psychologist, physical therapist, respiratory therapist, occupational therapist or speech therapist. Once the LOCD is completed by a qualified and licensed health professional, a clinical or non-clinical staff person may enter the LOCD information in CHAMPS. When the LOCD data are entered,

CHAMPS applies the MDHHS algorithm to determine eligibility.

3.3 INITIAL LOCD ASSESSMENT [CHANGE MADE 7/1/23]

The LOCD must be conducted in person (**revised per bulletin MMP 23-20**) by a qualified and licensed health professional (as defined in the Persons Authorized to Conduct the LOCD subsection) before the provider is eligible for Medicaid reimbursement for services rendered to the beneficiary. The LOCD must be conducted prior to or on the day of admission or enrollment. The LOCD assessment findings for all LOCDs conducted, including Door 0 (zero), which indicate the individual does not meet LOCD criteria must be entered online in CHAMPS. (LOCD Doors are described in the Nursing Facility Level of Care Determination Criteria section.)

* * *

3.7 ONGOING FUNCTIONAL ELIGIBILITY [CHANGE MADE 7/1/23]

Medicaid LTSS providers are required to ensure the individual continues to meet eligibility requirements on an ongoing basis. The functional eligibility that is assessed by the LOCD is one of the eligibility requirements. Therefore, Medicaid LTSS providers must ensure that individuals meet LOCD criteria on an ongoing basis. The LTSS provider is responsible for conducting a new LOCD if there is a significant change in the beneficiary's condition. When a provider possesses information that a beneficiary may no longer meet eligibility, the provider must conduct an in person reassessment. (**revised per bulletin MMP 23-20**) Such information may come in the form of progress notes, routine assessments, staff observations, or any other documentation that might call into question the continued functional eligibility of the beneficiary.

* * *

3.8.D. NEED TO CONDUCT A NEW LOCD [CHANGE MADE 7/1/23]

For the Doors that the passive determination is unable to assess, the provider must conduct an in-person LOCD prior to the current LOCD End Date. The provider must conduct a new LOCD prior to the End Date and enter it in CHAMPS within 14 days of the conducted date.

When the passive redetermination applies but the process cannot confirm eligibility based upon MDS or iHC assessment data, CHAMPS will create a LOCD Door 87 with an End Date 45 days from the date that record is loaded in CHAMPS, or until the current End Date, whichever is earlier. When the passive redetermination process continuously confirms that the beneficiary meets LOCD criteria, it is possible that the beneficiary will not require another in-person LOCD because the passive redetermination process confirms LOCD eligibility and creates a new LOCD with a new 365-day End Date. In addition, providers must conduct an in-person LOCD when there is a significant change in the beneficiary's condition, as defined by the program. **(revised per bulletin MMP 23-20)**

SECTION 4 – NURSING FACILITY LEVEL OF CARE DETERMINATION CRITERIA [CHANGE MADE 7/1/23]

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 an in-person **(revised per bulletin MMP 23-20)** 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.)

*MPM, July 1, 2023 version
Nursing Facility LOCD Chapter
Pages 1, 3-10
(Internal highlighting omitted)*

A LOCD is therefore mandated for all Medicaid-reimbursed admissions to nursing facilities or enrollments in MI Choice or PACE. Moreover, even after admission, a nursing facility resident must also continue to meet the outlined criteria in the LOCD on an ongoing basis.

The July 18, 2023 LOCD and subsequent secondary review were the basis for the action at issue in this case. To be found eligible for Medicaid nursing facility coverage the Petitioner must have met the requirements of at least one door:

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.

(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:

- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

(D) Eating:

- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

* * *

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

* * *

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3

1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

* * *

Scoring Door 4: The applicant must score “yes” in at least one of the nine categories and have a continuing need to qualify under Door 4.

* * *

Scoring Door 5: The applicant must have required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

* * *

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

1. A “Yes” for either delusions or hallucinations within the last 7 days.
2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

* * *

Scoring Door 7: The applicant must be a current participant, demonstrate service dependency, and meet all three criteria [participant for at least one consecutive year (no break in coverage); requires ongoing services to maintain current functional status; no other community, residential, or informal services are available to meet the applicant’s needs] to qualify under Door 7.

Exhibit A, pages 52, 56-59, 61-62

Here, acting for the Department, the nursing facility determined that Petitioner did not pass through any of the above doors in the July 18, 2023 LOCD and that he was therefore ineligible for nursing facility services through Medicaid.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that the Department 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 his burden of proof, and the Department's decision must therefore be affirmed, as the facts in this case reflect that Petitioner did not pass through any of the doors of the LOCD.

Even if Petitioner needs assistance with transferring like his guardian testified to and wrote in the written response to the Department's evidence, there is no evidence that, at the time of the LOCD in this case, Petitioner needed sufficient assistance with the specific tasks identified in Door 1 as Petitioner would need assistance with other tasks besides transferring to pass through that Door.

Moreover, nothing suggests that, during the relevant look-back periods, that Petitioner's medical conditions, or the effects of those conditions, met the criteria for passing through Doors 2, 4, or 6. The mere fact that Petitioner has a guardian is insufficient to pass through Door 2.

Similarly, there is also no evidence that any treatment Petitioner received met the criteria required by Doors 3, 4, 5 or 6.

Additionally, while Petitioner had been a nursing facility resident for over a year at the time of the LOCD, he was only receiving limited services and there is nothing to suggest that he requires ongoing services to maintain current functional status or that any services he does require are not available through other community, residential, or informal services.

Rather than arguing that Petitioner passed through any of specific doors of the LOCD, Petitioner's guardian instead expresses regret that he did not request a secondary review with iMPROve Health when given the opportunity. However, while the undersigned Administrative Law Judge sympathizes with Petitioner's guardian, it is undisputed that he was notified of his right to request a secondary review and did not do so.

Petitioner's guardian also argues that Petitioner should remain in the nursing facility because he would have transfer trauma if discharged. Regarding transfer trauma, the MPM states in part:

Borton vs. Califono Transfer Trauma	Transfer trauma protections apply to individuals with mental illness, intellectual/developmental disability or a related condition who were determined during a PASARR Level II evaluation to not need nursing facility services. Transfer Trauma is defined as any adverse psychological and/or physical effects occasioned by the transfer of a nursing facility patient that
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	would be materially detrimental to the physical or mental health of the patient.
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* * *

11.3 INVOLUNTARY TRANSFER OR DISCHARGE

11.3.A. CONDITIONS

A nursing facility must not involuntarily transfer or discharge a beneficiary unless:

- It is necessary for the welfare of the beneficiary, and the beneficiary's needs cannot be met in the facility; *
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; *
- It is necessary to protect the safety of individuals in the facility;
- It is necessary to protect the health of individuals in the facility; *
- The beneficiary has failed, after reasonable and appropriate notice, to pay (or to initiate payment under Medicaid) for a stay at the facility; or
- The facility ceases to operate.

The facility must include documentation in the beneficiary's clinical record for any of the above circumstances.

11.3.B. TRANSFER TRAUMA

For certain residents (defined below), transfer trauma must be considered when that resident may be moved due to a change in the level of nursing need.

Transfer trauma is defined as "any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient that would be materially detrimental to the physical or mental health of the patient."

Residents for whom transfer trauma must be considered include all those who have resided in the current nursing facility for at least one year, or who have been involuntarily transferred within the previous year. (A discharge to obtain acute care in an inpatient hospital, followed by an immediate readmission within three weeks to the same nursing facility, does not interrupt the continuity of a resident's stay.)

The SSA evaluates transfer trauma. This evaluation considers the social, mental and emotional adjustment of the resident, including the length of time that the resident has been in the nursing facility and the relationships that the resident has formed in the facility. This evaluation may also consider the resident's age, history and success of previous placements, and history of adapting to change. Consideration must also be given to the opinion of the attending physician regarding the resident's social and emotional adjustment and the physical effects of the proposed transfer.

Transfer trauma must be considered before the resident is notified of a nursing level of care change. When Medicaid is the payer source, Medicaid payment at the current level continues while transfer trauma is being considered.

If Medicaid was not the payer source immediately prior to the transfer trauma issue being raised, then Medicaid payment is not made until a decision is reached.

If the transfer trauma decision upholds the beneficiary's medical need to remain in a bed not certified for his present level of care, then the beneficiary's prior level of care will be retained to provide for continued Medicaid coverage.

If it is determined that there is no issue of transfer trauma, the beneficiary must be transferred to a bed or setting appropriate for the new level of care. MDHHS will change the Benefit Plan Assignment, which can be appealed by the beneficiary or their designated representative.

Concerns about involuntary transfer and/or transfer trauma should be reported to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

*MPM, July 1, 2023, version
Nursing Facility Coverages Chapter
Pages 18, 62-63*

Accordingly, while transfer trauma must be considered by the nursing facility prior to a change in nursing level of care or discharge, it is not part of the LOCD.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department correctly determined that Petitioner does not qualify for a nursing facility level of care.

IT IS, THEREFORE, ORDERED that:

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

SK/sj



Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 22nd day of November 2023.

S. James

S. James
**Michigan Office of Administrative
Hearings and Rules**

Via Electronic Mail:

Agency Representative
Florence Scott-Emuakpor
MDHHS Appeals Review Officer
Lansing, MI 48909
ScottF@michigan.gov

DHHS Department Representative
Mary Carrier
MDHHS Appeals Section
Lansing, MI 48909
MDHHS-Appeals@michigan.gov

DHHS Department Contact
Darleen Murphy Anderson
MDHHS-BPHASA
Lansing, MI 48933
MurphyAndersonD@michigan.gov

DHHS Department Contact
Ian Lowers
MDHHS-BPHASA
Lansing, MI 48933
LowersI1@michigan.gov

Authorized Hearing Representative

[REDACTED]
[REDACTED] MI [REDACTED]
[REDACTED]

Petitioner

[REDACTED]
[REDACTED] MI [REDACTED]
[REDACTED]