

ISSUE

Did Respondent properly reduce Petitioner's Home Care hours 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. Department is an organization that contracts with the Michigan Department of Health and Human Services (MDHHS) and oversees the PACE program in Petitioner's geographical area. (Exhibit A; Testimony).
2. Petitioner is a Medicaid beneficiary who has been receiving services through PACE. (Exhibit A; Testimony).
3. Prior to June 20, 2024, Petitioner was approved for and receiving 56 hours a week of home care services. (Exhibit A; Testimony).
4. On June 20, 2024, the Department sent Petitioner an Advance Negative Action Notice. The notice notified Petitioner of a reduction in home care hours and provided the following:

The reason for this action is due to you being independent with some activities of daily living (ADLS) and Instrumental activities of daily living (IADLs). You are able to perform laundry and some housekeeping tasks independently with assistive devices. You receive some informal support from your neighbor/friend. You also attend PACE for day center attendance 1x/week on Tuesday. The home care assessment and home care assessment tool revealed that you were utilizing 12hrs/week of homecare for shopping in community which is not included as part of homecare assessment tool.¹

5. At some point in time prior to July 17, 2024, Petitioner filed a local level appeal. (Exhibit A).
6. On July 17, 2024, the Department sent Petitioner a Appeal Notice of Denial. The notice indicated Petitioner's request for 56 hours per week of homecare was denied and further provided the following:

The reason for the action is due to your care needs being able to be met with the recommended 12-20 hours per week.²

7. On September 17, 2024, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a 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

¹ Exhibit A, p 5. _____

² Exhibit A, p 80.

Administrative Code, and the State Plan under Title XIX of the Social 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 Michigan Administrative Hearing System (MAHS) 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.³

The facts and evidence indicate there were no changes in Petitioner's condition or needs, and that the reduction was primarily the result of a change in the assessment tool utilized by the Department.

Dr. Zietlow provided testimony about both the old assessment tool and the new assessment tool and outlined the issues with the new tool and how it fails to fully capture a person's abilities to perform ADL's. Dr. Zietlow also discussed issues where the assessment confounded multiple ADL needs when those needs should have been evaluated independently.

In this case, the Petitioner argues since the new assessment tool did not accurately capture ADL's, the Department failed to take into account Petitioner's medical and

³ ~~Medicaid Provider Manual, Program of All-Inclusive Care for the Elderly, July 1, 2024, pp 1-2, 7-8.~~

physical needs as required by 42 CFR §460.92(b)(1).⁴ They went on to argue the new tool combined items that should be separate and unnecessarily limits selections to one category. This resulted in the new tool under-assessing Petitioner's needs, and as a result, undercut the number of hours of personal care Petitioner required.

During the hearing, the Department provided very little details or information regarding the new assessment tool and for the most part was unable to address the Petitioner's concerns about the new tool. Instead, the Department argued the tool was just one small aspect of the decision to reduce Petitioner's benefit allocation. The evidence; however, indicates the tool itself was the only variable that changed.

While there was some evidence in the Department's packet that indicated the Petitioner may not have been fully utilizing the approved services for their appropriate allocations, i.e., extended shopping periods, the Department did not present any evidence to corroborate these claims such as time studies etc.

Accordingly, this Administrative Law Judge finds that Petitioner has met their burden of proof; and that Department improperly reduced Petitioner's Home Care hours.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department improperly reduced Petitioner's Home Care hours

IT IS THEREFORE ORDERED that:

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

The Department is ordered to initiate the reassessment of the Petitioner for Home Care services and issue retroactive benefits if otherwise eligible and qualified.