

ISSUE

Did the Department properly determine that Petitioner is only liable for his Patient Pay A mount for any time at the Nursing Facility (NF) following the July 12, 2024, Level of Care Determination (LOCD)?

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 Medicaid beneficiary and former resident of NF REDACTED Village. (Exhibit A, p 9; Testimony.)
2. On November 18, 2023, a NF LOCD was completed via the Passive Redetermination process, which found Petitioner eligible to receive Medicaid reimbursed NF services through Door 5 - Skilled Rehabilitation Therapies. (Exhibit A, pp 49-56; Testimony.)

3. On July 12, 2024, a new LOCD was completed due to a significant change in condition, which found Petitioner to be ineligible for NF services paid by Medicaid through any of the LOCD doors. (Exhibit A, pp 33-40; Testimony.)
4. Following the July 12, 2024, LOCD, Petitioner was misinformed about his appeal and secondary review rights by NF staff. (Exhibit A, p 2; Testimony.) This fact was brought to the Department's attention in November 2024, and the Department informed the NF that, per policy, Petitioner had no financial liability beyond his REDACTED monthly Patient Pay Amount for any days in the NF following the July 12, 2024 LOCD. (*Id.*)
5. Petitioner has since left the NF. (Testimony.)
6. On November 4, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules (MOAHR). (Exhibit A, pp 817.)

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.

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.

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.

*Medicaid Provider Manual
Nursing Facility Level of Care Determination Chapter
July 1, 2024, pp 1-14*

Here, on November 18, 2023, a NF LOCD was completed via the Passive Redetermination process, which found Petitioner eligible to receive Medicaid reimbursed NF services through Door 5 - Skilled Rehabilitation Therapies. On July 12, 2024, a new LOCD was completed due to a significant change in condition, which found Petitioner to be ineligible for NF services paid by Medicaid through any of the LOCD doors. Following the July 12, 2024, LOCD, Petitioner was misinformed about his appeal and secondary review rights by NF staff. This fact was brought to the Department's attention in November 2024, and the Department informed the NF that, per policy, Petitioner had no financial liability beyond their \$868.00 monthly Patient Pay Amount for any days following the July 12, 2024, LOCD.

As indicated above, policy provides that a Medicaid beneficiary has the right to a Secondary Review and an appeal if they are determined no longer eligible for NF services by an LOCD. (MPM, NF LOCD Chapter, § 6.4; 6.5.) If a beneficiary timely requests an appeal, Medicaid will continue to pay the NF for the beneficiary's stay up to 30 days after a Decision and Order is issued by MOAHR. (*Id.*)

Here, the NF misinformed Petitioner about his appeal and secondary review rights, so Petitioner was unable to timely appeal the LOCD. Given this, Petitioner has no financial liability beyond his REDACTED monthly Patient Pay Amount for any days he stayed in the NF following the July 12, 2024, LOCD. The NF can rebill Medicaid for the 90 days following the July 12, 2024, LOCD, or until October 10, 2024. Again, Petitioner has no financial liability beyond his Patient Pay Amount, even if he stayed in the facility after October 10, 2024.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Department correctly determined that Petitioner has no financial liability beyond his Patient Pay Amount, even if he stayed in the facility after October 10, 2024.

IT IS THEREFORE ORDERED that:

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