ISSUE

Did the Department properly deny Petitioner's request for placement in an assisted living residence?

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 enrolled with Department through door 2, memory problem, moderately impaired daily decision making and understood. (Exhibit A, p 10; Testimony.)

2. On October 14, 2024, Petitioner made a request for placement at an assisted living facility due to Petitioner's informal support no longer being able to care for Petitioner due to her own health issues. (Exhibit A, p 25.)

3. On October 18, 2024, the Department sent Petitioner a Denial of Service notice. The notice indicated Petitioner's request for permanent placement would be denied effective October 18, 2024. The reason for the denial was Petitioner could be supported in the with SCPP interventions such as home care, day center, and revolving respites to help reduce caregiver burden. (Exhibit A, pp 2-3; Testimony.)

4. On November 21, 2024, the Department sent Petitioner a Notice of Decision on Appeal. The notice provided the following:

   > Upheld: The Internal Appeal Committee decided to uphold IDT's decision to deny Permanent Placement because supportive services within the home have not been maximized yet. Senior Care Partners interventions such as revolving respites, increased day center attendance, and homecare can still be implemented to help reduce caregiver burden.[1]

5. On January 28, 2025, an assessment took place. During the assessment, Petitioner was determined to be at baseline relative to when she started with the program. It was noted that if Petitioner were to return to an independent setting she would require additional supports including bathing, laundry, grocery shopping and housekeeping assistance. (Exhibit A, p 34; testimony.)

6. On January 14, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit A, p 37.)

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[1] Exhibit A, p 41.

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.

Effective November 1, 2004, the Michigan Department of Health and Human Services (MDHHS) implemented revised functional/medical eligibility criteria for Medicaid nursing facility, MI Choice, and PACE services. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria. Nursing facility residents must also meet Pre-Admission Screening/Annual Resident Review requirements. The Medicaid Provider Manual, Coverages and Limitations Chapter, Nursing Facilities Section, lists the policy for admission and continued eligibility process as well as outlines functional/medical criteria requirements for Medicaid-reimbursed nursing facility, MIChoice, and PACE services.

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.)

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.**[2]

A waiver under section 1915(c) of the [Social Security] Act allows a State to include as "medical assistance" under its plan, home and community-based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF [Skilled Nursing Facility], ICF [Intermediate Care Facility], or ICF/MR [Intermediate Care Facility/Mentally Retarded] and is reimbursable under the State Plan.[3]

The CFR's places certain requirements and limits on medical assistance programs and states that a Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.[4]

Home and community-based services means services not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter.[5]

> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
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> - Case management services.
> - Homemaker services.
> - Home health aide services.
> - Personal care services.
> - Adult day health services
> - Habilitation services.
> - Respite care services.

[2] Medicaid Provider Manual, Program of All-Inclusive Care for the Elderly, April 1, 2024, p 1-2.
[3] 42 CFR 430.25(c)(2).
[4] 42 CFR 440.230.
[5] 42 CFR 440.180(a).

- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.[6]

The Department is the responsible party who is assigned with the responsibility to determine the "amount, scope and duration of service provision based on the clinical observations of the enrollee's needs during the face-to-face Personal Care Assessment."[7]

In this case, the Petitioner has the burden of proof and must establish that placement in an AFC home is medically necessary to prevent institutionalization of Petitioner. In this case, the Petitioner has partially met that burden.

Petitioner is an enrollee with the PACE program who has not yet fully utilized the array of services that are being offered to Petitioner. But, while the PACE program has continued to look for ways to relieve the burdens placed on Petitioner's informal support by continuing to look for and offer solutions to lessen that burden, the evidence indicates Petitioner's informal support can no longer be an informal support; and the Department failed to take that into consideration in rendering their decision.[8]

Based upon the evidence presented, I find the Department did not act properly in denying Petitioner's request for AFC home placement. As a result, the Department's decision should be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department incorrectly determined that the Petitioner lacks the medical necessity requirements for AFC home placement.

IT IS, THEREFORE, ORDERED that:

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

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[6] 42 CFR 440.180(b).

[7] MDHHS Minimum Operating Standards for the MI Health Link Program an MI Health Link HCBS Waiver. January 1, 2018.

[8] There appears to be some evidence that arose following the final notice of appeal, but all prior decisions were focused on Petitioner returning to the home of the informal support and the informal support providing care with occasional respite. Something that was reported was no longer possible.

The Department must reassess Petitioner to determine whether Petitioner can reside in a private setting without the utilization of informal supports, and redetermine the appropriate level of support that is medically necessary.