

ISSUE

Did Respondent properly deny Petitioner's request for enrollment in PACE?

FINDINGS OF FACT

The ALJ, 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 and Medicare beneficiary who has applied for enrollment in PACE through Respondent. (Testimony of Petitioner's representative; Testimony of Respondent's representative).
3. She has been diagnosed with endometrial cancer, arthritis, diabetes and kidney disease. (Exhibit B, page 1).

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4. Due to her diagnoses and symptoms, Petitioner receives nursing care through her Medicare coverage. (Testimony of Petitioner's representative).
 5. On September 5, 2025, the Enrollment Specialist from Respondent completed a Level of Care Determination (LOCD) with Petitioner. (Testimony of Enrollment Specialist).
 6. In that LOCD, Petitioner was found to be ineligible for PACE based upon her failure to qualify via entry through one of the doors of that tool. (Testimony of Enrollment Specialist).
 7. Respondent also contacted the Department to discuss Petitioner's case with respect to one issue. (Exhibit C, pages 1-4).
 8. When doing so, Respondent misstated information about Petitioner. (Testimony of Respondent's representative; Testimony of Enrollment Specialist).
 9. The Department's representative responded that it did not sound like Petitioner met the requirements for passing through any door of the LOCD. (Exhibit C, page 1).
 10. Respondent then notified Petitioner by telephone that Petitioner's request for enrollment was denied. (Testimony of Respondent's representative).
 11. No written notice was sent to Petitioner. (Testimony of Respondent's representative).
 12. On September 29, 2025, MOAHR received the request for hearing filed in this matter with respect to the decision to deny Petitioner's request for enrollment. (Exhibit A, pages 1-11).

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 eligibility for it, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

SECTION 1 – GENERAL INFORMATION

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.)

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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.

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- Not concurrently enrolled in an HMO.

3.2 COMPLETION OF THE MEDICAID NURSING FACILITY LOC DETERMINATION

A PACE applicant's eligibility for coverage of nursing facility services and enrollment in the PACE organization is determined by the online application of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). The PACE organization will not be reimbursed for nursing facility services rendered when the applicant is determined not to meet the LOCD criteria. Providers must submit the LOCD information into its online version no later than fourteen (14) calendar days following the start of services. Instructions and required forms related to the completion of the Medicaid Nursing Facility Level of Care Determination are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The LOCD must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. Nonclinical staff may perform the evaluation when clinical oversight by a professional is performed. The PACE organization will be held responsible for enrolling only those participants who meet the criteria outlined in this section.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the online version in the following situations:

- all new enrollments of Medicaid-eligible beneficiaries.
- re-enrollment of Medicaid-eligible beneficiaries.
- significant change in condition of a current PACE Medicaid-eligible beneficiary.

The online LOCD must be completed only once for each admission or readmission to the program.

*MPM, July 1, 2025 version
PACE Chapter, pages 1, 3-4*

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Moreover, regarding the required LOCD referenced in the above policy, the MPM also states in 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) 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.

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SECTION 3 – NURSING FACILITY LEVEL OF CARE DETERMINATION PROCESS

3.1 LOCD ASSESSMENT REQUIREMENT FOR REIMBURSEMENT

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 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

The LOCD must be conducted in person 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.)

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SECTION 4 – NURSING FACILITY LEVEL OF CARE DETERMINATION CRITERIA

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 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, 2025 version
Nursing Facility LOCD Chapter
Pages 1, 3, 9-10*

A LOCD is therefore mandated for all Medicaid-reimbursed admissions to PACE.

If the PACE agency finds that a beneficiary is not eligible for PACE after conducting the LOCD, it is required to send an Adverse Action Notice:

3.10 ADVERSE ACTION NOTICE

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the organization must immediately issue an adverse action notice to the beneficiary or their authorized representative. The action notice must include all of the language of the sample letters for long term care. Copies of the letters are available on the MDHHS

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website. (Refer to the Directory Appendix for website information.)

As with any benefit denial, the beneficiary may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDHHS website. (Refer to the Directory Appendix for MOAHR contact and website information.)

*MPM, July 1, 2025 version
PACE Chapter, page 6*

Moreover, in addition to requesting an administrative hearing following receipt of an adverse action notice, an applicant may also request an immediate review through the Department:

3.11 NURSING FACILITY LEVEL OF CARE PROCESS - IMMEDIATE REVIEW UPON ISSUANCE OF AN ADVERSE ACTION NOTICE

The MDHHS designee may conduct a Nursing Facility (NF) Level of Care (LOC) Process Immediate Review for a Medicaid pending/eligible beneficiary who was determined functionally/medically ineligible based on the online Michigan Medicaid Nursing Facility Level of Care Determination. The beneficiary, or their representative, must request an Immediate Review before noon of the first working day after the date of receipt of the notice as follows:

- The MDHHS designee will request the PACE organization to provide medical documentation by close of business of the first business day after the date the beneficiary requests an Immediate Review.
- The MDHHS designee will review the medical documentation, obtain information from the beneficiary and/or their representative, and notify the beneficiary and the provider of the determination within three business days of receipt of the medical documentation.

The beneficiary (or representative) may still request an MDHHS appeal of the Michigan Medicaid Nursing Facility

Level of Care Determination. (Refer to the Directory Appendix for contact information.)



Here, Respondent determined that Petitioner did not pass through any of the above doors in the LOCD, and that she was therefore ineligible for PACE.

However, after doing so, Respondent failed to send the required adverse action notice. It is undisputed Respondent only notified Petitioner via telephone and, by doing so, Respondent erred.

Moreover, while Petitioner was still able to request a hearing in this matter despite not receiving the required notice, Respondent's error was not harmless and the matter must therefore be reversed.

Petitioner is disputing whether she passes through Door 8, and she was never notified of her right to request an immediate review with respect to that door through the Department's designee. And, while Respondent's representative argued that there was no need to notify Petitioner of her right to an immediate review because Respondent had already checked with the Department, that is wrong as a matter of policy; it is undisputed that Respondent provided the Department with incorrect information; and no full immediate review of all the relevant evidence was conducted.

Accordingly, Respondent's decision must be reversed, a new LOCD should be conducted and, if Respondent again finds that Petitioner did not pass through any of the doors of the LOCD, proper notice must be sent to Petitioner, including notification of her right to request both an immediate review and an administrative hearing.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent improperly denied Petitioner's request for enrollment in PACE.

IT IS, THEREFORE, ORDERED that:

- Respondent's decision is **REVERSED**, and it must initiate a reassessment of Petitioner's request, with proper notice to be sent if Respondent again finds that Petitioner is ineligible for PACE.