ISSUE

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

FINDINGS OF FACT

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

1. In REDACTED of 2026, Petitioner was admitted as a resident at Medilodge, a Medicaid-certified nursing facility. (Exhibit A, page 19; Testimony of MDS Coordinator).

2. At the time of Petitioner's admission, nursing facility staff completed a Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) with respect to Petitioner in which they found that Petitioner met the criteria for a Medicaid nursing facility level of care. (Exhibit A, pages 20-28).

3. Specifically, they found that Petitioner met criteria by passing through Door 1 of the LOCD based on his need for limited assistance with bed mobility, transfers, and toilet use. (Exhibit A, pages 20-28).

4. Petitioner received occupational therapy (OT) and physical therapy (PT) while in the facility, with Petitioner being discharged from both OT and PT on January 16, 2026. (Exhibit A, pages 106-113).

5. On February 9, 2026, nursing facility staff conducted another LOCD with respect to Petitioner. (Exhibit A, pages 29-37; Testimony of MDS Coordinator).

6. In the LOCD, Petitioner was found to be ineligible for a Medicaid reimbursable nursing facility level of care based upon his failure to qualify via entry through one of the seven doors of that tool. (Exhibit A, pages 29-37).

7. On February 9, 2026, the nursing facility then sent Petitioner written notice that the LOCD conducted on February 9, 2026, had determined that Petitioner no longer meet the functional eligibility requirements for Medicaid long-term services. (Exhibit A, pages 38-39).

8. On February 12, 2026, MOAHR received the request for hearing filed by Petitioner in this matter with respect to that decision. (Exhibit A, page 40).

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) describes the policy for admission and continued eligibility for Medicaid-reimbursable 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, January 1, 2026 version*
> *Nursing Facility Coverages Chapter, page 7*

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.

* * *

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.)

* * *

3.7 ONGOING FUNCTIONAL ELIGIBILITY

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. 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

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.

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: FRAILTY

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, January 1, 2026 version*
> *Nursing Facility LOCD Chapter, pages 1, 3-10*

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 February 9, 2026, LOCD was 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 or identified exception:

> **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 119, 123-126, 128-129

Here, acting for the Department, the nursing facility determined that Petitioner did not pass through any of the above doors in the February 9, 2026, 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 ALJ 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.

Petitioner generally testified about his medical conditions, including a foot amputation, frostbite on his other foot and seizures, but he is required to show that he passes through a specific door of the LOCD; and he has failed to make such a showing here.

For example, there is no evidence that at the time of the LOCD in this case, Petitioner needed assistance with any of the specific tasks identified in Door 1 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.

Similarly, there is also no evidence that any treatment Petitioner received met the criteria required by Doors 3, 4, 5 or 6. While Petitioner has received skilled therapies in the past, he was subsequently discharged; and it is undisputed that Petitioner was not receiving any skilled rehabilitation therapies during the relevant look-back period as required to pass through Door 5.

Additionally, Petitioner has not been a nursing facility resident for over a year at the time of the LOCD; and he, therefore, did not pass through Door 7.

The parties did discuss discharge planning and subsequent medical care that Petitioner may require during the hearing, but both discussions are beyond the scope of this case. As noted by the Departmental Analyst, if Petitioner does undergo a significant change, then the facility should complete another LOCD.

Accordingly, the Department's decision in this case was proper and must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly determined that Petitioner does not require a Medicaid reimbursable nursing facility level of care.

IT IS, THEREFORE, ORDERED that:

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