STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

,

Appellant
_______________________/

Docket No. 2009-34331 KBH

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on . , appeared on behalf of the Appellant. , appeared as a witness for the Appellant.

, represented the Michigan Department of Community Health (MDCH or Department). , appeared as a witness for the Department.

ISSUE

Did the Department properly determine Appellant was not eligible for the Home Care Children program?

FINDINGS OF FACT

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

1. The Appellant is not a Medicaid beneficiary. The Appellant is enrolled in his family's insurance program. (Exhibit 3).

2. Appellant's family's insurance program has a lifetime maximum of . (Exhibit 3).

3. Appellant's family's insurance program has a yearly benefit maximum. (Exhibit 3).

4. The Appellant was born on , with physical disabilities resulting in him being ventilator dependent. (Exhibit 1, pp 4-5). As of , Appellant had a tracheostomy and gastrostomy. (Exhibit 1, pp 4-5).

5. In , Appellant resided in .

6. On , the Department Children's Special Health Care Section Division received a request for consideration of Appellant's eligibility for Home Care Children coverage from . (Exhibit 1, p 2).

7. After discharge from the hospital in early , Appellant resided in his parent's home. The Appellant received in-home nursing care, covered by insurance program. (Exhibit 3).

8. The cost of care charged to Appellant's insurance was approximately per month for in-home nursing care. (Exhibit 3).

9. In or after informed Appellant that he had reached his yearly benefit maximum. (Exhibit 3).

10. As of Appellant's family's has a remaining lifetime benefit maximum of . (Exhibit 3).

11. MDCH CSHCS authorized 180 hours of R.N./L.P.N. nursing respite for Appellant after Appellant reached his yearly maximum. Appellant utilized the 180 hours of nursing respite before the date of fair hearing. Appellant's in-home nursing care is currently covered by Children Are Precious, a non-profit organization, for up to 80 hours of nursing care. Appellant's parents estimate the 80 hours of non-profit covered nursing care will exhaust by mid- .

12. Utilizing the monthly insurance cost as an expenditure figure for Appellant's in-home care plan, divided by a 30 day month, results in Appellant's actual private insurance per diem cost for in-home nursing care as .

13. Utilizing the MDCH Medicaid rate of per hour for in-home nursing care, multiplied by eight hours per day, results in a MDCH Medicaid estimated per diem cost for in-home nursing care of for Appellant.

14. The inpatient DRG (Diagnostic Related Group) outlier per diem payment for a ventilator dependent individual is approximately . The cap for Appellant's Medicaid covered home care is .

15. The MDCH Medicaid estimated per diem payment of for Appellant's in-home nursing care does not exceed the Medicaid medical institution per diem.

16. On , MDCH CSHCS sent Appellant a notice of Home Care Children eligibility denial. (Exhibit 1, p 2).

17. The reason stated in the notice of denial was: "It has been determined that the estimated cost of services for in-home services would be greater that(sic) the estimated cost for the child's services in a medical institution, i.e., a hospital level of care. The basis for this decision is within Bridges Eligibility Manual (BEM) 170 of the Department of Human Services." (Exhibit 1, p 2).

18. On , the State Office of Administrative Hearings and Rules received the Appellant's request for hearing. Appellant protests the denial of Home Care Children eligibility and indicate he needs the eligibility to cover the cost of in-home nursing care for the months not covered by or any other program. (Exhibit 2).

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.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) added a provision to Title XIX of the Social Security Act which expanded Medicaid coverage to children with a medical institution level of care need but were otherwise ineligible for Medicaid due to a higher family income. The program is also referred to as the Katie Beckett program. *See P.L. 97-248, Section 134.* In essence, the Katie Beckett provision in TEFRA allowed states to waive the requirement for considering parental income in the process of determining Medicaid eligibility.

The implementing provision of the Code of Federal Regulations, as related to TEFRA individuals under age 19 who would be eligible for Medicaid if they were in a medical institution is, in pertinent part:

> (a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.
>
> (b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:
>
> (1) The child requires the level of care provided in a hospital, SNF, or ICF.
> (2) It is appropriate to provide that level of care outside such an institution.
> (3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.
>
> (c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

42 CFR 435.225 (Underline added).

As required in the CFR, Michigan's Medicaid State Plan agreement with the federal government specifies the method by which it determines cost-effectiveness of caring for disabled children at home:

> Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
>
> Statewide average DRG outlier per diem payment is determined for the child's diagnosis. This becomes the cap for Title XIX covered home care. Care plan is developed and all medically necessary services are provided. At the end of the fiscal year, expenditures for services are compared to DRG allowable cap. If expenditures exceed cap, amount is "cost settled" against Title V, using state dollars. No Title XIX claims will be made exceeding cap.

State Plan under Title XIX of the Social Security Act, Supplement 3 to Attachment 2.2-A, effective October 1, 1991

The State of Michigan's policy is consistent with the Social Security Act, Code of Federal Regulations and State Plan. The State of Michigan Bridges Eligibility Manual (BEM) lists the criteria for eligibility and delineates the division of eligibility determination responsibility between the Department of Community Health and the Department of Human Services:

> **DEPARTMENT POLICY**
>
> **MA Only**
>
> This is an SSI-related Group 1 MA category.
>
> MA is available to a child who requires institutional care but can be cared for at home for less cost.
>
> The child must be under age 18, unmarried and disabled. The income and assets of the child's parents are **not** considered when determining the child's eligibility.
>
> The Department of Community Health (DCH) and DHS share responsibility for determining eligibility for Home Care Children. All eligibility factors must be met in the calendar month being tested.
>
> **NONFINANCIAL ELIGIBILITY FACTORS**
>
> **DCH Responsibilities**
>
> DCH determines if medical eligibility exists. That is:
>
> - The child requires a level of care provided in a medical institution (i.e., hospital, skilled nursing facility or intermediate care facility); and
>
> - It is appropriate to provide such care for the child at home; and
>
> - The <u>estimated</u> MA cost of caring for the child <u>at home</u> does **not** exceed the <u>estimated</u> MA cost for the child's care in a <u>medical institution</u>. (Underline added.)
>
> DCH also obtains necessary information to determine whether the child is disabled and forwards it to the DHS State Review Team (SRT). If the criterion in BEM 260 is met, disability will be certified on a DHS-49-A, Medical-Social Eligibility Certification, by the SRT.

Communication to the Local Office

If the child is disabled and requirements (a) through (c) above are met, DCH Central Office sends a Policy Decision (MSA-1785) and the medical packet to the appropriate DHS local office. The MSA-1785 certifies that the medical requirements in "**DCH Responsibilities**" above are met.

DCH will also notify the DHS local office when this category can no longer be used for a child. Pursue eligibility for other MA categories when a child is no longer eligible for this category.

Local Office Responsibilities

Do not authorize MA under this category without a MSA-1785 instructing you to do so. Use this category when the child is *not* an SSI or FIP recipient. Use this category before using a Group 2 category.

If a MSA-1785 is received for a child who is **not** an MA applicant or recipient, treat the MSA-1785 as a request for assistance. Contact the child's parents concerning an MA application for the child. Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 270, Pursuit of Benefits.

Local offices are responsible for disability reviews. See BEM 260.

INQUIRIES

Inquiries from medical providers or parents concerning medical eligibility (requirements in "**DCH Responsibilities**" above) under this category should be directed to a Nurse Consultant at:

Department of Community Health
Public Health Administration
Bureau of Family, Maternal & Child Health, Children's Special Health Care Services
Lewis Cass Building, 6th Floor
320 S. Walnut Street
Lansing, MI 48913

Phone: (517) 335-8983

FINANCIAL ELIGIBILITY FACTORS

Financial eligibility is determined by the DHS local office. Only the child's own income and assets are counted. Do **not** deem income and assets from the child's parents to the child.

Groups

The child is a fiscal and asset group of one.

Assets

The child's countable assets cannot exceed the asset limit in BEM 400.

Countable assets are determined based on MA policies in BEM 400 and BEM 401.

Divestment

Do **not** apply policy in BEM 405.

Income Eligibility Apply the MA policies in BEM 500, 530, and 540 to determine net income. Income eligibility exists when the child's net income is equal to or less than:

- $637 for months in calender(sic) year 2008.
- $623 for months in calender(sic) year 2007.

State of Michigan Department of Human Services,
Home Care Children Bridges Eligibility Manual
(BEM 170) 10-1-2008, *page 3 of 3.*

The State of Michigan operates a medical coverage program for children eligible under the TEFRA provision with approval from the Centers for Medicare and Medicaid Services (CMS). The program is titled Home Care Children and is housed within the Department of Community Health (MDCH) Children's Special Health Care Services Division (CSHCS). Because the State of Michigan opted to operate the Home Care Children program it must offer the program statewide, and must determine for each child requesting eligibility determination, whether he meets the three conditions of 42 CFR 435.225(b). Because the TEFRA provision includes eligibility for Medicaid benefits the Department is required to send a written notice of Home Care Children denial and the Appellant possessed a right to a Medicaid fair hearing. *See 42 CFR 431.200, et seq.*

On [redacted], MDCH CSHCS received a request for Home Care Children eligibility determination from Children's Hospital on behalf of the Appellant. On [redacted], MDCH CSHCS sent Appellant a notice of eligibility denial. (Exhibit 1, p 2). The notice of eligibility denial stated the following reason for denial:

> It has been determined that the estimated cost of services for in home services would be greater that(sic) the estimated cost for the child's services in a medical institution, i.e., a hospital level of care. The basis for this decision is within Bridges Eligibility Manual (BEM) 170 of the Department of Human Services." (Exhibit 1, p 2).

When comparing the Department's written reason for denial, to the CFR, State Plan and DHS BEM 170 policy language, it appears that the Department's denial utilized the proper cost-effectiveness methodology for determining Home Care Children eligibility. Applying the undisputed facts to the case however, demonstrates that the MDCH estimated per diem Medicaid cost of services for caring for Appellant at home ([redacted]) does not exceed the Medicaid cost for Appellant's care in a medical institution/DRG outlier per diem ventilator dependent payment ([redacted]). Therefore the Department should not have denied Appellant's eligibility request on the basis of cost-effectiveness.

The Department's representative stated that MDCH interpreted the BEM 170 policy as a cost-savings: its methodology looks back on the actual amount of Medicaid dollars spent on an inpatient individual in the previous year and compares the **actual** Medicaid inpatient dollars spent to an **estimated** cost of in-home care. The Department's representative explained that because Appellant was not eligible for Medicaid in the prior year the actual Medicaid inpatient dollars spent for the preceding year was [redacted]. The Department's representative added that the actual [redacted] Medicaid cost amount was compared to an estimated cost of future in-home care and because the in-home care would be greater than [redacted], no "cost-savings" would occur.

The Department relied on a "cost-saving" measure that conflicts with the CFR, State Plan and BEM 170 "cost-effectiveness" methodology. The methodology utilized by the Department is not consistent with the CFR, State Plan and BEM 170 language. The CFR, State Plan and BEM 170 are the governing authority for Home Care Children eligibility. The language of all three is explicit: an estimated cost of inpatient care is compared to an estimated cost of in-home care. Contrastingly, the Department methodology when determining Appellant's eligibility utilized an **actual** cost of inpatient care and compared it to an **estimated** cost of in-home care.

The Department's use of an actual cost of Medicaid inpatient care was in conflict with all three of the governing authorities. The use of actual Medicaid inpatient cost fails to employ cost-effectiveness as the Medicaid cost of care outside an institution being no higher than the estimated Medicaid cost of appropriate institutional care. Instead, the Department's cost-saving methodology replaces the State Plan DRG outlier per diem cap with whether actual Medicaid dollars were used in a medical institution the previous year. It must also be pointed out that using the Department's inaccurate interpretation, no child could be determined eligible

for Home Care Children because he never would have spent actual Medicaid dollars in the preceding year; he is applying for Home Care Children because he is not eligible for Medicaid.

The preponderance of undisputed evidence in this case demonstrates that the MDCH estimated per diem cost of services for Appellant's in-home care does not exceed the cost for Appellant's care in a medical institution/DRG outlier per diem ventilator dependent payment. The Department should perform a redetermination of Appellant's eligibility utilizing all criteria articulated in the CFR and BEM 170, and including the cost-effectiveness methodology explicit in the CFR and BEM 170.

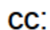
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department did not properly determine Appellant was not eligible for the Home Care Children program.

IT IS THEREFORE ORDERED that:

- The Department's decision is REVERSED.
- The Department must redetermine whether Appellant is eligible for Home Care Children using the CFR, State Plan and BEM 170 criteria for cost-effectiveness.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health



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Date Mailed: 10/28/2009

***** NOTICE *****
The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.