STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Phone: (877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-007903 TRN
Case No. [redacted]

Appellant.
_____/

HEARING DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted]. Appellant appeared and testified. [redacted], Clinical Social Worker, appeared and testified on Appellant's behalf. [redacted], Appeals Review Officer, represented the Respondent, Michigan Department of Health and Human Services (MDHHS or the Department). [redacted], Departmental Analyst for Prior Authorization and [redacted], Adult Services Worker appeared and testified on behalf of the Department.

On [redacted], Appellant waived the timeliness standard and this case was adjourned and sent to Department of Health and Human Services to determine if a Medicaid Policy Exception was appropriate and can be provided to Appellant because she is a kidney dialysis patient and requires continuous uninterrupted care and always meets her spend down from month to month. The Department has not yet made a decision on the Medicaid Policy Exception and the 90 day timeliness standard has expired as of [redacted]. The record closed [redacted] (when the case was returned to this Administrative Law Judge for issuance of a Decision and Order) along with Docket #15-007904 TRN and #15-008018 DHS to determine if a Medicaid Exception is appropriate.

ISSUE

Did the Department properly determine that Appellant was not eligible for Medical Transportation (TRN) until her spend down was met?

FINDINGS OF FACT

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

1. Appellant is a Medicare and Medicaid beneficiary.

2. Appellant was a TRN benefit recipient.

3. Appellant has been diagnosed with a brain tumor, Behcet's syndrome, chronic body pains, gastroparesis, diabetes, anemia, neuropathy, bleeding stomach ulcer, 2 frozen shoulders, gallstones, renal failure, and loss of balance/fall risk. (State's Exhibit A page 13)

4. Appellant has a Medicaid spend down.

5. Appellant requires medical transportation to kidney dialysis three days per week.

6. Medical Transportation has not been provided because the department determined that Appellant has a Medicaid spend down and is not eligible for transportation until she meets her monthly spend down amount.

7. On [redacted], Appellant filed a request for a hearing to contest the Department's cancellation of her medical transportation.

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.

Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened for supportive services to assist the client in applying for Medicaid (MA).

Home help services payments cannot be authorized prior to establishing Medicaid eligibility and completing a face-to-face assessment with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.

- Certification of medical need.
- Need for service, based on a complete comprehensive assessment indicating a functional limitation of level 3 or greater for at least one activity of daily living (ADL).
- Appropriate Level of Care (LOC) status.

Adult Services Manual (ASM) 105, page 1

The Code of Federal Regulations (CFR) affords a Medicaid beneficiary a right to a fair hearing when the Department takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *42 CFR 438.400.*

Clients with a scope of coverage 20, 2C, or 2B are not eligible for Medicaid until they have met their MA deductible obligation.

Department Medicaid Policy dictates:

This item completes the Group 2 MA income eligibility process.

Income eligibility exists for the calendar month tested when:

- There is no excess income.
- Allowable medical expenses (defined in **EXHIBIT I**) equal or exceed the excess income.

When **one** of the following equals or exceeds the group's excess income for the month tested, income eligibility exists **for the entire month**:

- Old bills (defined in EXHIBIT IB).
- Personal care services in clients home, (defined in Exhibit II), Adult Foster Care (AFC), or Home for the Aged (HA) (defined in EXHIBIT ID).
- Hospitalization (defined in EXHIBIT IC).
- Long-term care (defined in EXHIBIT IC).

When **one** of the above does **not** equal or exceed the group's excess income for the month tested, income eligibility begins either:

- **The exact day of the month** the allowable expenses **exceed** the excess income.

- **The day after the day of the month** the allowable expenses **equal** the excess income.

In addition to income eligibility, the fiscal group must meet all other financial eligibility factors for the category processed. However, eligibility for MA coverage exists only for qualified fiscal group members. A qualified fiscal group member is an individual who meets all the nonfinancial eligibility factors for the category processed. Bridges Eligibility Manual (BEM) 545, pages 1-2

A group with excess income can delay deductible for one or more future months based on allowable old bills; see EXHIBIT IB in this item.

Determining the Number of Months to Delay Deductible

1. Do the total old bills equal or exceed the group's excess income?

   - If **yes**, go to 2.
   - If **no**, go to 5.

2. Divide the total old bills by the group's excess income. Drop any fractions. The result equals the number of months the group may delay deductible.

   - If the result is more than one month, go to 3.
   - If not, authorize MA for the future month. Go to 5.

3. Authorize MA for the additional months, but not more than a total of six future months. Go to 4.

4. Set a follow-up for whichever is **earliest**:

   - The fifth future month, **or**
   - The month before the last month of MA coverage. Go to 5.

5. Transfer the case to active deductible effective the month following the last month the group's old bills exceeded its excess income.

   Go to Deductible in this item.

Old Bills Follow-up

At follow-up:

- Re-verify the group's liability for old bills, if any.
- Authorize up to six additional months of MA if the group is eligible
- Notify the group of:
  - Additional MA coverage, or
  - Transfer to active deductible (see step 5 above). BEM 545, page 10

Medical Services

Medical services include the following:

- Cost of a diabetes patient education program.
- Service animal (e.g., guide dog) or service animal maintenance.
- Personal cares services in home, AFC, or HA; see EXHIBIT ID.
- Transportation* for any medical reason.
- Medical service(s) provided by any of the following:
  - Anesthetist.
  - Certified nurse-midwife.
  - Chiropractor.
  - Christian Science practitioner, nurse or sanatorium.
  - Clubhouse psychosocial rehabilitation programs.
  - Dentist.
  - Family planning clinic.
  - Hearing aid dealer.
  - Hearing and speech center.
  - Home health agency.
  - Hospice; see EXHIBIT III.
  - Hospital; see EXHIBIT IC.
  - Laboratory.
  - Long-term care facility; see EXHIBIT IC.
  - Maternal support services provider.
  - Medical clinic.
  - Medical supplier. ***
  - Mental health clinic.
  - Nurse.
  - Occupational therapist.
  - Ophthalmologist.
  - Optometrist.
  - Oral surgeon. Orthodontist.
  - Pharmacist. ***
  - Physical therapist.
  - Physician (MD or DO).

- Podiatrist.
- Psychiatric hospital; see EXHIBIT IC.
- Psychiatrist.
- Psychologist.
- Radiologist.
- Speech therapist.
- Substance abuse treatment services provider.
- Visiting nurse.

* Includes ambulance at actual cost and other transportation for medical services at the rates in BAM 825. Includes clients driving themselves for episodic and pharmacy trips at the rate they are paid in BAM 825 for chronic ongoing trips.

** Includes purchase, repair and rental of supplies, such as:

- Prosthetic devices.
- Orthopedic shoes.
- Wheelchairs.
- Walkers.
- Crutches.
- Equipment to administer oxygen.
- Personal response system (for example Lifeline Emergency Services).

*** Includes:

- Legend drugs (that is, can only obtained by prescription).
- Aspirin, ibuprofen and acetaminophen drug products which are prescribed by a doctor and dispensed by a pharmacy.
- Non-legend drugs and supplies, such as:
  - Insulin.
  - Needles.
  - Syringes.
  - Drugs for the treatment of renal (kidney) diseases.
  - Family planning drugs and supplies.
  - Ostomy supplies.
  - Oxygen.
  - Surgical supplies.
  - Nicotine patches and gum.
  - Incontinence supplies.

It does not include medicine chest and first aid supplies, such as:

- Band-Aids.
- Alcohol.
- Cotton swabs.
- Nonprescription cold remedies.
- Ointments.
- Thermometers. BEM 545, page 16-17

Such payments can be used to meet the client's deductible as follows:

- Count the entire expense for the month during which the service was provided.

- Count **only** the portion of the expense the client must actually pay when using an expense as an old bill; see EXHIBIT IB. (BEM 545, page 18)

Department policy dictates that the goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. BEM 105, page 1. MA-only eligibility is determined on a calendar month basis. Unless policy specifies otherwise, circumstances that existed, or are expected to exist, during the calendar month being tested are used to determine eligibility for that month. When determining eligibility for a future month, assume circumstances as of the processing date will continue unchanged unless you have information that indicates otherwise. Federal law gives them the right to the most beneficial category. The most beneficial category is the one that results in eligibility or the least amount of excess income. BEM 150, page 2.

Medical transportation policy dictates:

> County MDHHS staff **must** verify client eligibility prior to the authorization of transportation in order to determine who is responsible for payment.
>
> Payment for medical transportation may be authorized only after it has been determined that it is not otherwise available, and then for the least expensive available means suitable to the client’s needs.
>
> Medical transportation is available to:
>
> - Family Independence Program (FIP) recipients.
>
> - MA recipients (including those who also have Children's Special Health Care Services (CSHCS) coverage.
>
> - Supplemental Security Income (SSI) recipients.

- Healthy Michigan Plan (HMP) recipients.

Unless otherwise indicated, medical transportation coverage for HMP recipients is the same as medical transportation coverage for MA recipients. BAM 825, page 1

Medical transportation is available to obtain medical evidence or receive any MA-covered service from any MA-enrolled provider, including:

- Chronic and ongoing treatment.
- Prescriptions.
- Medical supplies.

Onetime, occasional and ongoing visits for medical care. BAM 825, page 2

Medical transportation must be administered in an equitable and consistent manner. Local MDHHS offices must have procedures to assure medical transportation eligibility and that payment reflect policy. BAM 825, page 5

In the instant case, Appellant has a Medicaid Spend down. The Department indicates that Medical Transportation was not authorized because Appellant lacks proper Medicaid coverage to meet eligibility criteria because she did not meet her spend-down. However, the evidence indicates that Appellant meets her spend-down every single month because she receives kidney dialysis on a continuous basis. Each dialysis visit meets the spend-down deductible by itself. Thus, Appellant would not need to use Home Help Services (HHS) or Medical Transportation care services costs to meet her spend-down if the Department representative would appropriately coordinate her care and put the Medicaid on the computer sooner rather than later in the month. If the Medicaid is properly put on for the dialysis for the first dialysis visit the Medicaid spend-down would be met by at least the second of every month and Appellant's coverage for transportation and HHS would be properly covered. It would appear that the Department should accept Appellant's old bills for uncovered services from prior months so that Appellant's coverage can be continuous in case the dialysis does not occur on the first of the month. The Department's determination to terminate Appellant's request for Medical Transportation was in not accordance with policy found in the Bridges Eligibility Manual or Adult Services Manual. The Department did not appropriately deny payment for or cancel Appellant's Medical Transportation because Appellant has no Medicaid eligibility Appellant has established that she does meet her spend-down each month with her ongoing kidney dialysis. The Department must properly coordinate eligibility determination and authorize appropriate medical services so that Appellant can receive MA covered services to assist her for medical treatment during her chronic illness. The department's actions must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly cancelled the Appellant's HHS/improperly failed to pay Appellant's HHS case based on the available information.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **REVERSED**. The Department is **ORDERED** to reinstate Appellant's HHS to the date of suspension, place Appellant's Medicaid case on the system as is appropriate and pay to Appellant any benefits to which she is entitled as of the first day of kidney dialysis in each month. The Department is **ORDERED** to go back and apply any 'old bills' to Appellant's case as is appropriate to ensure that Appellant retains continued Medicaid benefits as long as she receives kidney dialysis for end stage kidney failure.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

LYL[redacted]

cc: [redacted]

Date Signed: [redacted]

Date Mailed: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.