GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

Date Mailed: February 28, 2020
MOAHR Docket No.: 19-012430
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Ellen McLemore

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 42 CFR 438.400 to 438.424; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on February 19, 2020, from Detroit, Michigan. Petitioner was represented by his Authorized Hearing Representative (AHR)/attorney, . Also present on Petitioner's behalf was his Power of Attorney (POA), , and his secondary POA, . The Department of Health and Human Services (Department) was represented by Assistant Attorney General (AAG) Kyle Bruckner. Also present on behalf of the Department was Cami Johnson, Eligibility Specialist.

ISSUE

Did the Department properly determine that Petitioner should be subject to a post-eligibility Patient Pay Amount (PPA)?

FINDINGS OF FACT

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

1. Petitioner was an ongoing Medical Assistance (MA) benefit recipient under the Ad-Care category (Exhibit A, p. 8).
2. On August 6, 2019, Petitioner was admitted to the hospital (Exhibit A, p. 13).
3. On August 13, 2019, Petitioner was discharged from the hospital (Exhibit A, p. 13).

4. On August 13, 2019, Petitioner was admitted to [redacted] (Exhibit A, p. 11).

5. On August 14, 2019, the Department sent Petitioner a Health Care Coverage Determination Notice informing him that he was eligible for MA benefits subject to a PPA of $747 per month effective September 1, 2019, ongoing (Exhibit A, pp. 18-20).

6. On September 21, 2019, Petitioner was discharged from [redacted] (Exhibit A, p. 15).

7. On November 8, 2019, Petitioner submitted a request for hearing disputing the Department's actions.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), Department of Health and Human Services Reference Tables Manual (RFT), and Department of Health and Human Services Emergency Relief Manual (ERM).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Petitioner was an ongoing MA recipient under the Ad-Care category. On August 6, 2019, Petitioner entered the hospital. On August 13, 2019, Petitioner was discharged from the hospital and transferred to [redacted]. On August 14, 2019, the Department sent Petitioner notice that effective September 1, 2019, ongoing, he would be subject to a monthly PPA.

In this case, Petitioner's AHR argued that Petitioner should not be subject to a PPA. Specifically, Petitioner's AHR contended that Petitioner does not fall within the definition of a Long Term Care (LTC)/Hospital (L/H) patient.

A post-eligibility PPA is an L/H patient's share of the cost of LTC or hospital services. BEM 546 (July 2019), p. 1. The Department will determine the PPA when MA eligibility exists for L/H patients under various MA categories, including Group 1 SSI-related. BEM 546, p. 1. Ad-Care is a group 1 SSI-related MA program. BEM 163 (July 2017), p. 1.

Policy defines an L/H patient as an MA client who was in the hospital and/or an LTC facility in an L/H month. BPG Glossary (April 2019), p. 40. An L/H month is a calendar month containing at least one day that is part of a period in which a person was (or is expected to be) in an LTC facility and/or hospital for at least 30 consecutive days, and no day that the person was a waiver patient. BPG Glossary, p. 40. LTC means being in any of the following: (i) a nursing home that provides nursing care; (ii) a county medical care facility that provides nursing care; (iii) a hospital long-term care unit; (iv) a Department facility that provides active psychiatric treatment; (v) a special MR nursing home; and (vi) a Department facility for individuals with intellectual disability that provides ICF/ID nursing care. BPG Glossary, p. 42.

Petitioner's AHR argued that Petitioner received skilled nursing services at , as opposed to long-term care services. In support of his argument, Petitioner's AHR provided Petitioner's Medicare billing summary showing that Medicare covered a portion of Petitioner's expenses at , which was designated as a skilled nursing facility (Exhibit 1, pp. 1-6). Petitioner's AHR also included information from Medicare.gov stating that Medicare does not cover long-term care (also called custodial care), if that is the only care that the patient needs (Exhibit 1, p. 8). However, Medicare will cover care in a certified skilled nursing facility (Exhibit 1, p. 7). The documentation defines long-term care as a range of services and support for personal care needs (Exhibit 1, p. 8). It states that long-term care is help with basic personal tasks of everyday life like bathing, dressing and using the bathroom (Exhibit 1, p. 8). It does not include medical care (Exhibit 1, p. 8).

Although Medicare distinguishes between "skilled nursing services" and "long-term care services," state policy pertaining to PPAs applies when an individual is at a long-term care facility. State policy defines an LTC to include a nursing home that provides nursing care. BPG Glossary, p. 42. Similarly, federal regulations provide that post-eligibility treatment of income of institutionalized individuals applies to individuals in medical institutions and intermediate care facilities. 42 CFR 435.725; 435.726; and 435.832. A medical institution means an institution that: (i) is organized to provide medical care, including nursing and convalescent care; (ii) has the necessary profession personnel, equipment, and facilities to manage the medical, nursing and other needs of patients on a continuing basis in accordance with accepted standards; (iii) is authorized under State law to provide medical care; and (iv) is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution. 42 CFR 435.1010. Thus, federal regulations, consistent with state policy, require the calculation of a PPA when an individual is in a long-term care facility.

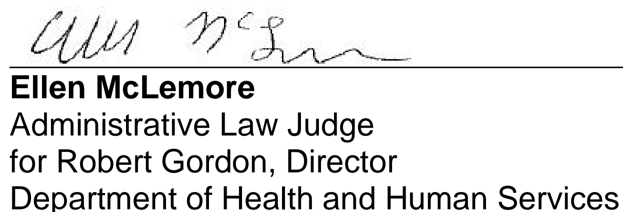
This conclusion is consistent with that found at Medicaid.gov, which states that Medicaid covers certain inpatient, comprehensive services as institutional benefits. The word institutional has several meanings in common use, but a particular meaning in

federal Medicaid requirements. In Medicaid coverage, institutional services refers to specific benefits authorized in the Social Security Act. These include hospital services and Nursing Facility (NF) services. Medicaid.gov further provides that NF services are provided by Medicaid certified nursing homes, which primarily provide three types of services: (i) skilled nursing or medical care and related services; (ii) rehabilitation needed due to injury, disability, or illness; and (iii) long term care which is health-related care and services (above the level of room and board) not available in the community needed regularly due to a mental or physical condition. See: https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html and https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/index.html.

Petitioner's AHR contends that because Petitioner was receiving "skilled nursing services," as opposed to "long-term care services," he should not be subject to a PPA. While long term care and skilled nursing services are different types of services provided by Medicaid certified NFs, all Medicaid certified NFs would fall within the definition of an LTC facility, per state policy, and a medical institution, per federal policy. Neither state, nor federal policy, distinguishes between the type of services provided by the nursing home or medical institution. Therefore, because Petitioner was in a facility that provides LTC services, the Department properly determined that Petitioner was an L/H patient. As it follows, the Department properly determined that Petitioner was subject to a monthly PPA.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds that the Department acted in accordance with Department policy when it determined Petitioner should be subject to a PPA. Accordingly, the Department's decision is **AFFIRMED**.



EM/cg

Ellen McLemore
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email: MDHHS-Oakland-2-Hearings
AG-HEFS-MAHS
D. Smith
EQAD
BSC4- Hearing Decisions
MOAHR

Authorized Hearing Rep. - Via First-Class Mail:

Authorized Hearing Rep. - Via First-Class Mail:

Petitioner – Via First-Class Mail:

Counsel for Petitioner – Via First-Class Mail: