STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted],

Claimant

Reg. No.: 2009-27558
Issue No.: 3015, 2013, 2000
Case No.:
Load No.:
Hearing Date:
August 17, 2009
Macomb County DHS

ADMINISTRATIVE LAW JUDGE: Linda Steadley Schwarb

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a hearing was held on August 17, 2009. The claimant appeared and testified.

ISSUE

1. Did the Department of Human Services (DHS or department) properly determine that claimant is not eligible for Ad-Care and Medicare Savings Programs due to excess income?

2. Did the department properly determine that claimant's Food Assistance Program (FAP) group was no longer eligible for FAP benefits due to excess income?

3. Does the undersigned Administrative Law Judge have jurisdiction to address claimant's complaints with regard to Medical Transportation?

FINDINGS OF FACT

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

1) Claimant is a recipient of full Medicaid coverage through the Waiver program.

2) On December 17, 2008, the department calculated claimant's eligibility for Medical Assistance (MA). At that time, claimant was receiving a monthly pension in the gross amount of $445 as well as Retirement, Survivors and Disability Insurance (RSDI) income in the gross amount of $1248.40.

3) On December 17, 2008, when calculating claimant's eligibility for MA, the department used the gross amount of claimant's pension and RSDI income ($1693) and provided a $20 disregard from that income. This resulted in a determination that claimant had net income in the amount of $1673.

4) Based upon a net income of $1673, the department determined that claimant was not eligible for Ad-Care or the Medicare Savings Programs due to excess income.

5) Claimant was a recipient of FAP benefits in a group of one.

6) Claimant has a $735 per month rental obligation and is responsible for her heat and utility cost.

7) On May 4, 2009, when the department recalculated claimant's on-going eligibility for FAP benefits, claimant was receiving $1320.40 per month in gross RSDI income and $445 in gross pension income.

8) Claimant pays health insurance premiums in the amount of $104 per month. Claimant did not provide the department with verification of her current prescription expenses.

9) On May 4, 2009, the department notified claimant that effective June 1, 2009, it would terminate claimant's FAP benefits because of excess income.

10) On June 1, 2009, claimant's FAP benefits were terminated.

11) On or about April 23, 2009, claimant met with her DHS worker and, among other things, orally requested assistance with medical transportation expenses.

12) On May 4, 2009, the department sent claimant a DHS-54a, Medical Needs Form, and a DHS-4674, Medical Transportation Statement, to be completed and returned to the department.

13) At the time of the hearing, claimant had provided the department with a DHS-54a completed by claimant's physician but had not yet provided the department with a DHS-4674 which identified a transportation provider.

14) On June 17, 2009, claimant filed a hearing request to protest the department's:

- closure of claimant's FAP;
- determination that claimant did not qualify for Ad-Care and Medicare Savings Programs; and
- failure to provide assistance with medical transportation.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

In this case, departmental policy at the time of determination was as follows:

> *Income* means benefits or payments measured in money . . . *Unearned income* means all income that is NOT earned . . . The amount of income counted may be more than the amount a person actually receives because it is the amount before any deductions including deductions for taxes and garnishments. The amount before any deductions is called the **gross** amount . . . Income remaining after applying the policy in this item is called **countable**. Count income that is NOT specifically excluded. PEM Item 500, Page 1.

> … retirement income includes annuities, private pensions, military pensions, and state and local government pensions.
>
> Count the gross benefit as unearned income . . .
>
> RSDI is available to retired and disabled persons, their dependents, and survivors of deceased workers.
>
> Count the gross benefit amount as unearned income. PEM Item 500, Page 29.

In this case, the department followed policy in counting claimant's gross income from her pension and the RSDI program. Departmental policy requires that the gross amount of these income sources be counted. The department properly provided a disregard of $20 from claimant's income. This resulted in a net income of $1673. In reviewing the Ad-Care and Medicare Savings Program income limits seen at RFT 242, page 1, the undersigned finds that the department properly concluded that claimant was not eligible for those programs based upon excess income. Accordingly, the department's determination on this matter must be affirmed.

The Food Assistance Program (FAP) (formerly known as the Food Stamp (FS) program) is established by the Food Stamp Act of 1977, as amended, and is implemented by the federal regulations contained in Title 7 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the FAP program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3001-3015. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

When determining eligibility for FAP benefits, the household's total income must be evaluated. All earned and unearned income from each household member must be included unless they are specifically excluded. PEM Item 500. The standard deduction of $135 is allowed for each household. Certain non-reimbursable medical expenses above $35 a month not paid by other medical insurance may be deducted. Another deduction from income is provided if

monthly shelter cost are in excess of 50% of the household's income after all the other deductions have been allowed. PEM Items 500 and 554; Program Reference, Table 225; 7 CFR 273.2.

In this case, the undersigned Administrative Law Judge has reviewed the FAP budget prepared by the department and finds that the department properly computed the group's net monthly income. The department was required to take into consideration the group's unearned (pension and RSDI) income. The standard deduction of $135 was allowed. The FAP budget prepared for claimant's case correctly reflects the group's income and disregards from that income. Claimant did not provide the department with verification of her current prescription expenses. Hence, the department could only consider claimant's health insurance premiums when calculating claimant's medical expenses. Further, the budget sheet was accurately computed. The calculations, based upon verification provided to the department by claimant, provided in a net monthly income figure of $1056. Federal regulations at 7 CFR 273.10 provides standards for the amount of a household's benefits. The department, in compliance with federal regulation, has prepared a Food Assistance Income Limit Table at RFT 250. The table provides that a household of one with a monthly net countable income in excess of $867 is not eligible for FAP benefits. The department correctly determined that claimant's FAP group's net monthly income precluded eligibility for FAP. Accordingly, this Administrative Law Judge must find that the department properly determined that claimant is no longer eligible for FAP benefits.

In this matter, departmental policy with regard to Medical Transportation is as follows:

> You must furnish information in writing and orally, as appropriate to all applicants and to all other individuals who request it acknowledging that medical transportation is **ensured** for transportation to and from medical services providers for MA-covered services . . .

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 clients needs.

Medical transportation is available to

- FIP recipients.
- MA recipients.
- SSI recipients.

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.
- one-time, occasional and ongoing visits for medical care.

PAM Item 825, Page 1

Compute the cost of the client's medical transportation when you receive verification that transportation has been provided.

Calculate the total number of roundtrip miles traveled. Use the distance from the client's home to the medical services destination(s) and back to the client's home. Accept any reasonable client or transporter statement of the mileage. Otherwise, use map miles to determine mileage. PAM Item 825, Page 8.

Use the MSA-4674, Medical Transportation Statement, to:

- authorize payment for routine travel expenses that do not require advance payment,

- verify that transportation was provided.

Use a MSA-4674 to authorize payment whenever a less expensive means for medical transportation is not otherwise available. Use comparable documentation from the provider and/or transporter if the client is unable to obtain the MSA-4674 prior to a medical visit.
A separate MSA-4674 is required for each medical provider or transporter. PAM 825, Page 11.

You must receive the MSA-4674 within 90 days from the date of service in order to authorize payment. Do not make payment less frequently than monthly . . .

> The client and medical provider(s) (or their staff) must sign the form. The transporter must sign if payment is to be issued to the transporter, except for mass transit transporters. PAM 825, Page 12.
>
> Documentation of expenses on a MSA-4674, MSA-4674A or DHS-223 (attached to the DHS-1291) must include the following:
>
> - Patient's name and address.
> - Case number and recipient's ID number.
> - Transportation provider's name, address, social security number or tax ID #.
> - Travel or appointment date.
> - Medical provider's name, address and signature.
> - Number of miles traveled (roundtrip).
> - Payment method (client or vendor).
>
> There are two payment methods:
>
> - Direct client payment (client is the payee), or
> - Direct vendor payment (transportation provider is the payee).
>
> The client and transporter must determine who will be the payee. If the transporter is to be payee, the transportation provider completes section III of the MSA-4674. Make direct client payment if section III is not completed. PAM 825, Page 12.
>
> Use a DHS-301, Client Notice (Medical Transportation Denial), to notify a client that medical transportation is denied (see RSF). The notice contains:
>
> - The action being taken.
> - The reason(s) for the denial.
> - PAM 825 is the legal base.
> - The individual's right to request a hearing . . .
>
> DCH's Administrative Tribunal is responsible for conducting hearings on medical transportation. The DHS-301 instructs the client to send the hearing request to DCH. PAM Item 825, Page 13.

Departmental policy mandates that administrative hearings on medical transportation issues are to be referred to the DCH Administrative Tribunal. Thus, the undersigned Administrative Law Judge has no jurisdiction to address claimant's complaints with regard to the

Medical Transportation program. The department is ordered to refer claimant's request for hearing on this matter to the DCH Administrative Tribunal.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that:

1. The Department of Human Services properly determined that claimant is not eligible for Ad-Care and Medicare Savings Programs due to excess income;
2. The department properly determined that claimant's Food Assistance Program is no longer eligible for FAP benefits due to excess income;
3. That the undersigned Administrative Law Judge has no jurisdiction to address claimant's complaints regarding the Medical Transportation program.

Accordingly, the department is AFFIRMED with regard to its determination as to claimant's eligibility for Medical Assistance and the Food Assistance Program. The department is further ordered to refer claimant's request for hearing regarding medical transportation to the Department of Community Health Administrative Tribunal.

Linda Steadley Schwarb
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: 10/20/09

Date Mailed: 10/23/09

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

LSS/dj

cc: [redacted]