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: 2010-26281
Issue No: 2006
Case No: [redacted]
Load No: [redacted]
Hearing Date:
April 14, 2010
Branch County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

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 telephone hearing was held on Apri 14, 2010. Claimant was represented at the hearing by [redacted]

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-P) based upon it's determination that claimant failed to provide verification information in a timely manner?

FINDINGS OF FACT

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

(1) On August 24, 2009, a Medicaid application was filed on claimant's behalf. Claimant was a patient of a nursing facility.

(2) Due to there being a community spouse, an initial asset assessment was also needed.

(3) A verification checklist was mailed on September 14, 2009, with due date of September 25, 2009.

(4) On September 21, 2009, claimant's representative emailed a request for 10 more days.

(6) The due date was changed to October 5, 2009.

(7) Verifications were received, however, additional verifications were needed for the American Benefit Annuity.

(8) On September 29, 2009, the worker received 2 pages of the annuity contract.

(9) On September 30, 2009, an email was sent to claimant's representative questioning the verification sent.

(10) A letter was received from claimant's representative on October 7, 2009, stating in the 3rd paragraph that he was still trying to get a copy of the contract from American Benefit.

(11) On December 14, 2009, an email was received from claimant's representative stating that he was still trying to get the annuity.

(12) The verification that was available was then sent to Lansing for review on December 15, 2009.

(13) An email was received on December 18, 2009, from Lansing stating there was not enough information to evaluate the annuity.

(14) A Medical Program eligibility notice (DHS-4598) was mailed on December 22, 2009, denying the application for Medical Assistance and the initial asset assessment.

(15) On December 22, 2009, the department caseworker sent claimant notice that the application was denied based upon the failure to provide verification information.

(16) On December 29, 2009, claimant filed a request for a hearing to contest the department's negative action.

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).

Cooperation, Verification, and Eligibility Determination (Rev. 01-01-08)

DEPARTMENT POLICY

All Programs

Clients have rights and responsibilities as specified in this item.

The local office must do **all** of the following:

. Determine eligibility.
. Calculate the level of benefits.
. Protect client rights. PAM, Item 105, p. 1.

CLIENT OR AUTHORZED REPRESENTATIVE RESPONSIBILITIES

Responsibility to Cooperate

All Programs

Clients must cooperate with the local office in determining initial and ongoing eligibility. This includes completion of the necessary forms. PAM, Item 105, p. 5.

Client Cooperation

The client is responsible for providing evidence needed to prove disability or blindness. However, you must assist the client when they need your help to obtain it. Such help includes the following:

- Scheduling medical exam appointments
- Paying for medical evidence and medical transportation
- See PAM 815 and 825 for details. PEM, Item 260, p. 4.

A client who refuses or fails to submit to an exam necessary to determine disability or blindness **cannot** be determined disabled or blind and you may deny or close the case. PEM, Item 260, p. 4.

All Programs

Clients must completely and truthfully answer all questions on forms and in interviews. PAM, Item 105, p. 5.

The client might be unable to answer a question about himself or another person whose circumstances must be known. Allow the client at least 10 days (or other timeframe specified in policy) to obtain the needed information. PAM, Item 105, p. 5.

FAP Only

Do **not** deny eligibility due to failure to cooperate with a verification request by a person **outside** the group. In applying this policy, a person is considered a group member if residing with the group and is disqualified. PAM, Item 105, p. 5.

Refusal to Cooperate Penalties

All Programs

Clients who are able but refuse to provide necessary information or take a required action are subject to penalties. PAM, Item 105, p. 5.

Responsibility to Report Changes

All Programs

This section applies to all groups **except** most FAP groups with earnings.

Clients must report changes in circumstances that potentially affect eligibility or benefit amount. Changes must be reported **within 10 days**:

- after the client is aware of them, or
- the start date of employment. PAM, Item 105, p. 7.

Income reporting requirements are limited to the following:

- Earned income
  - Starting or stopping employment
  - Changing employers
  - Change in rate of pay
  - Change in work hours of more than 5 hours per week that is expected to continue for more than one month
- Unearned income
  - Starting or stopping a source of unearned income
  - Change in gross monthly income of more than $50 since the last reported change. PAM, Item 105, p. 7.

See PAM 220 for processing reported changes.

Other reporting requirements include, but are n**ot** limited to, changes in:

- Persons in the home
- Marital status
- Address and shelter cost changes that result from the move
- Vehicles
- Assets
- Child support expenses paid
- Health or hospital coverage and premiums
- Day care needs or providers. PAM, Item 105, pp. 7-8.

For TLFA only, the client must report to the specialist any month the work requirement is not fulfilled.

Explain reporting requirements to all clients at application, redetermination and when discussing changes in circumstances. PAM, 105, p. 8.

Verifications

All Programs

Clients must take actions within their ability to obtain verifications. DHS staff must assist when necessary. See PAM 130 and PEM 702. PAM, Item 105, p. 8.

LOCAL OFFICE RESPONSIBILITIES

All Programs

Ensure client rights described in this item are honored and that client responsibilities are explained in understandable terms. Clients are to be treated with dignity and respect by all DHS employees. PAM, Item 105, p. 8.

VERIFICATION AND COLLATERAL CONTACTS

DEPARTMENT POLICY

All Programs

Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements.

Obtain verification when:

. required by policy. PEM items specify which factors and under what circumstances verification is required.

. required as a local office option. The requirement **must** be applied the same for every client. Local requirements may **not** be imposed for MA, TMA-Plus or AMP without prior approval from central office.

. information regarding an eligibility factor is unclear, inconsistent, incomplete or contradictory. The questionable information might be from the client or a third party. PAM, Item 130, p. 1.

Verification is usually required at application/redetermination **and** for a reported change affecting eligibility or benefit level. PAM, Item 130, p. 1.

Verification is **not** required:

- when the client is clearly ineligible, or
- for excluded income and assets **unless** needed to establish the exclusion. PAM, Item 130, p. 1.

Obtaining Verification

All Programs

Tell the client what verification is required, how to obtain it, and the due date (see "**Timeliness Standards**" in this item). Use the DHS-3503, Verification Checklist, or for MA redeterminations, the DHS-1175, MA Determination Notice, to request verification. PAM, Item 130, p. 2.

The client must obtain required verification, but you must assist if they need and request help. PAM, Item 130, p. 2.

If neither the client nor you can obtain verification despite a reasonable effort, use the best available information. If no evidence is available, use your best judgment.

Exception: Alien information, blindness, disability, incapacity, incapability to declare one's residence and, for FIP only, pregnancy must be verified. Citizenship and identity must be verified for clients claiming U.S. citizenship for applicants and recipients of FIP, SDA and MA. PAM, Item 130, p. 3.

Timeliness Standards

All Programs (except TMAP)

Allow the client 10 calendar days (**or** other time limit specified in policy) to provide the verification you request. If the client cannot provide the verification despite a reasonable effort, extend the time limit at least once. PAM, Item 130, p. 4.

An initial asset assessment is used to determine how much of a couples assets are protected for the community spouse. An initial asset assessment means determining the couples

total countable assets as of the 1st day of the 1st continuous period of care that began on or after September 30, 1989. BEM, Item 402, p. 6. The department is supposed to complete an initial asset assessment and mail notices within 45 days. BEM, Item 402, p. 7. Annuities are similar legal devices to trusts. Annuities are a written contract with a commercial insurance, establishing a right to receive specified periodic payments for life or for a term of years. They are usually designed to be a source of retirement income. Only certain types of annuities are excluded as resources. BEM, Item 400, p. 16. Converting countable resources to income through the purchase of an annuity or the amendment of an existing annuity on or after September 1, 2005, is considered transfer for less than market value unless the annuity meets the conditions listed below:

- Is commercially issued by a company licensed in the United States and issued by a licensed producer
- Irrevocable
- Is purchased by an applicant or recipient of Medicaid or their spouse and solely for the benefit of applicant or recipient or their spouse
- Is sound and returns the principle and interest within the annuitants life expectancy and
- Payments must be insubstantially equally monthly payments and continue for the term of the payout
- An annuity purchased or amended on/after February 8, 2006, listed in the State of Michigan as a remainder beneficiary or as a second remainder beneficiary as a community spouse or minor or disabled child for an amount at least equal to the amount of the Medicaid benefits provided. The naming of the state in the first or second position must be verified at application or redetermination. (BEM, Item 401, pp. 4-5)

In the instant case, this Administrative Law Judge finds that claimant and claimant's representative did not provide the annuity contract. There was no information provided by claimant's representative as to whether or not the annuity was actuarially sound, and whether or not the annuity was revocable or irrevocable and whether or not it was going to make payments in substantially equal monthly amounts nor did it have any information to whether or not the State of Michigan was a remainder beneficiary. The department did provide the claimant with at least 3 months worth of extensions for the provision of the verification information. This Administrative Law Judge finds that claimant and claimant's representative failed or refused to provide verification information in a timely manner and even when they did provide the verification information, it was not substantial enough to make a determination as to whether or not the annuity was actuarially sound. Therefore, the department did not have enough information in which to make a determination or in which to conduct an initial asset test. The department's case must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that the department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant and claimant's representative did not provide verification information in a timely manner and did not provide adequate verification information so that the department could make a determination as to claimant's eligibility or lack there of for Medicaid benefits. Based upon the fact that claimant's representative and claimant provided insufficient verification information, the department was unable to make an initial asset determination.

Accordingly, the department's decision is AFFIRMED.

/s/
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Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: May 17, 2010

Date Mailed: May 18, 2010

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.

LYL/alc

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