STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No: 201140818
Issue No: 2026
Case No: [redacted]
Hearing Date: August 16, 2011
Wayne County DHS

ADMINISTRATIVE LAW JUDGE: Christopher S. Saunders

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 August 16, 2011. The claimant personally appeared and provided testimony.

ISSUE

Did the department properly close the claimant's Medical Assistance (MA) case?

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 claimant was a recipient of MA benefits.

2. The claimant was assigned a deductible of [redacted] per month.

3. The claimant did not meet the deductible assigned for at least one of the three months preceding the closure date.

4. On May 28, 2011, the claimant was sent a notice of case action informing her that her MA case would be closed due to her failure to meet the deductible assigned for at least one of the three preceding months.

5. The claimant submitted a hearing request on June 8, 2011.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R

400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his claim for assistance is denied. MAC R 400.903(1).

Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The department will provide an administrative hearing to review the decision and determine the appropriateness. BAM 600.

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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Program Reference Manual (PRM).

The MA program is also referred to as Medicaid. BEM 105. 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. The Medicaid program is comprised of several sub-programs or categories. One category is FIP recipients. BEM 105. Another category is SSI recipients. BEM 105. There are several other categories for persons not receiving FIP or SSI. BEM 105. However, the eligibility factors for these categories are based on (related to) the eligibility factors in either the FIP or SSI program. BEM 105. Therefore, these categories are referred to as either FIP-related or SSI-related. BEM 105.

To receive Medicaid under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant women, receive Medicaid under FIP-related categories. For MA only, a client and the client's community spouse have the right to request a hearing on an initial asset assessment only if an application has actually been filed for the client. BAM 105. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. BEM 105.

For purposes of MA in general, the terms Group 1 and Group 2 relate to financial eligibility factors. BEM 105. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. BEM 105. The income limit, which varies by category, is for nonmedical needs such as food and shelter. BEM 105. Medical expenses are not used when determining eligibility for FIP-related and SSI-related Group 1 categories. BEM 105. For Group 2, eligibility is possible even when net income exceeds the income limit. BEM 105. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories. BEM 105.

BEM 544 applies to all FIP-related and SSI-related Group 2 MA categories. The department must use the appropriate protected income level (PIL) (defined below) for each fiscal group. BEM 544. The department may include other need items only when the fiscal group meets the requirements for them. BEM 544. The department shall then determine the fiscal group's total needs. BEM 544. The department will then look to BEM 545 to complete the income eligibility determination. BEM 544. The protected income level (PIL) is a set allowance for non-medical need items such as shelter, food and incidental expenses. BEM 544. RFT 240 lists the Group 2 MA PILs based on shelter area and fiscal group size. BEM 544.

A fiscal group is established for each person requesting MA (see BEM 211) and budgetable income is determined for each fiscal group member. BEM 536. Since how a client's income must be considered may differ among family members, special rules are used to prorate a person's income among the person's dependents, and themselves. BEM 536.

For an MA recipient, a future month budget must be performed at redetermination and when a change occurs that may affect eligibility or a post-eligibility PPA. BEM 530. For an MA deductible client, a future month budget must be performed at redetermination and when a change occurs that may affect deductible status. BEM 530. Countable income is income remaining after applying MA policy in BEM 500. BEM 530.

MA-only eligibility is determined on a calendar month basis. BEM 105. 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. BEM 105. When determining eligibility for a future month, assume circumstances as of the processing date will continue unchanged unless you have information that indicates otherwise. BEM 105.

Persons may qualify under more than one MA category. BEM 105. Federal law gives them the right to the most beneficial category. BEM 105. The most beneficial category is the one that results in eligibility or the least amount of excess income. BEM 105.

Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred. BEM 545. Active Deductible cases will be opened on Bridges without ongoing Group 2 MA coverage as long as:

- The fiscal group has excess income, and
- At least one fiscal group member meets all other Group 2 MA eligibility factors. BEM 545.

Periods of MA coverage are added each time the group meets its deductible. BEM 545. Each calendar month is a separate deductible period. BEM 545. The first deductible period:

- Cannot be earlier than the processing month for applicants.

- Is the month following the month for which MA coverage is authorized for recipients. BEM 545.

According to policy, the fiscal group's monthly excess income is called a deductible amount. BEM 545. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month tested. BEM 545.

The group must report expenses by the last day of the third month following the month in which the group wants MA coverage. BEM 545. Department policy BAM 130 explains verification and timeliness standards. BEM 545.

The department is authorized to close an active deductible case when any of the following occur:

- No one in the group meets all nonfinancial eligibility factors.
- Countable assets exceed the asset limit.
- The group fails to provide needed information or verification. BEM 545.

The department is instructed to add periods of MA coverage each time the group meets its deductible. BEM 545. An exception exists when the client is eligible for (or receiving) benefits through the Adult Medical Program (AMP) which is governed by BEM 640.

The department will redetermine MA eligibility for active deductible cases at least every 12 months unless the group has not met its deductible within the past three months. BEM 545. If a group has not met its deductible in at least one of the three calendar months before that month and none of the members are QMB, SLM or ALM eligible, Bridges will automatically notify the group of closure. BEM 545.

In the case at hand, the claimant did not dispute that she did not use her MA benefits or meet her assigned deductible for at least one of the preceding three months before her case was closed. The claimant was further not able to challenge the amount of the deductible assigned to her for her MA benefits. Because the claimant did not present any testimony contrary to the department's assertion that she had not met her deductible, the department acted properly according to policy in closing the claimant's MA case due to her failure to meet her deductible for at least one month in the preceding three months.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department properly closed the claimant's MA case.

Accordingly, the department's actions are **AFFIRMED**. SO ORDERED.

/s/
Christopher S. Saunders
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: August 29, 2011

Date Mailed: August 30, 2011

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 60 days of the filing of the original request.

The Claimant 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 date of the rehearing decision.

CSS/cr

cc: [redacted]