STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No: 201145310
Issue No: 2017, 2026, 3014
Case No: [redacted]
Hearing Date: August 31, 2011
Marquette County DHS

ADMINISTRATIVE LAW JUDGE: Corey A. Arendt

HEARING DECISION

This matter is before me pursuant to MCL 400.9 and MCL 400.37 upon Claimant's request for a hearing received on July 22, 2011. After due notice, a telephone hearing was held on August 31, 2011. The Claimant and the Department appeared by telephone and provided testimony.

ISSUE

Whether the Department properly reduced Claimant's Food Assistance Program (FAP) benefits, denied Claimant's Medical Assistance (MA) benefits?

FINDINGS OF FACT

I find as material fact, based upon the competent, material and substantial evidence on the whole record:

1. As of July 13, 2011, Claimant was receiving FAP and MA benefits.

2. Claimant's Senior/Disabled/Veteran (SDV) group size is 1

3. On July 1, 2011, the Department sent the Claimant a Notice of Case Action. The Notice indicated the Claimant was being denied Medicaid because she has not met the set deductable for any month during the three months prior to July 2011.

4. On July 13, 2011, the Department reviewed prior medical expenses from the Claimant and determined there were inaccurate medical expenses.

5. On July 13, 2011, the Department sent the Claimant a Notice of Case Action. The Notice indicated the Claimant was denied MA and her FAP benefits were being reduced.

6. As of July 13, 2011, the Claimant received monthly RSDI of [redacted] as well as monthly Child Support.

7. Claimant has a child who visits her at her home two days of the week. The child lives with the Claimant's parents the other five days a week.

8. The Claimant did not meet her monthly deductable in any month during the three months prior to July 2011.

9. On July 22, 2011, the Claimant filed a request for hearing.

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.

Bridges will assist you in determining who must be included in the Food Assistance Program (FAP) group prior to evaluating the nonfinancial and financial eligibility of everyone in the group.

FAP group composition is established by determining:

1.Who lives together.

2.The relationship(s) of the people who live together.

3.Whether the people living together purchase and prepare food together or separately, and

4.Whether the person(s) resides in an eligible living situation (see Living Situations).

The primary caretaker is the person who is primarily responsible for the child's day-to-day care and supervision in the home where the child sleeps more than half of the days in a calendar month, on average, in a twelve-month period.

When a child spends time with multiple caretakers who do not live together (e.g., joint physical custody, parent/grandparent, etc.), determine a primary caretaker. Only one

person can be the primary caretaker and the other caretaker(s) is considered the absent caretaker(s). The child is always in the FAP group of the primary caretaker. If the child's parent(s) is living in the home, he/she must be included in the FAP group.

Exception: If otherwise eligible, the absent caretaker may receive FAP benefits for the child, when the child is visiting the absent caretaker for more than 30 days (i.e., not temporarily absent from the primary caretaker's home.)

Determine primary caretaker by using a twelve month period. The twelve month period begins when a primary caretaker determination is made.

Group composition policy for MA is very similar. Only persons living with one another can be in the same group. The primary caretaker is the parent who is primarily responsible
for the child's day-to-day care and supervision in the home where the child sleeps more than half the days in a month, when averaged over a twelve month period. The twelve month period begins at the time the determination is being made. Vacations and visitation with the absent parent do not interrupt primary caretaker status. BEM 211.

Therefore, based on the evidence submitted, I do not find the Claimant to be the primary caretaker for her child and therefore the child should not be included in the Claimant's group for FAP or MA purposes.

The Medical Assistance (MA) program was established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The department administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies for the MA programs are contained in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), the Bridges Reference Manual (BRM), and the Reference Tables Manual (RFT).

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.

The Medicare Savings Programs are made up of 3 categories, they are:

1. Qualified Medicare Beneficiaries, also called full-coverage QMB and just QMB. Program group type is QMB.

2. Specified Low-Income Medicare Beneficiaries, also called limited-coverage QMB and SLMB. Program group type is SLMB.

3. Q1 Additional Low-Income Medicare Beneficiaries, also referred to as ALMB and as just Q1. Program group type is ALMB. BEM 165.

There are both similarities and differences between eligibility policies for the three categories. Benefits among the three categories also differ. Income is the major determiner of category. A person who is eligible for one of these categories cannot choose to receive a different Medicare Savings Program category. For example, a person eligible for QMB cannot choose SLMB instead. All eligibility factors must be met in the calendar month being tested. BEM 165.

Benefits of Medicare Savings Programs differ depending on the program. QMB Benefits pay Medicare premiums and Medicare coinsurances and Medicare deductibles. SLMB Benefits pay Medicare Part B premiums. While ALMB Benefits pay Medicare Part B premiums provided funding is available. The Department of Community Health decides whether funding is available. BEM 165. General information about Medicare and information about the Buy-In program is available in BAM 180.

The Department makes separate Medicare Savings Program determinations for the following clients if they are entitled to Medicare Part A:

- Medicare Savings Programs-only.
- Group 2 MA (FIP-related and SSI-related).
- Extended Care (BEM 164).
- Healthy Kids.
- TMA-Plus.

Automatic QMB Person's receiving MA under the following categories and entitled to Medicare Part A are considered QMB eligible without a separate QMB determination. The QMB coverage date begins the calendar month after the processing month. The processing month is the month during which you make the eligibility determination. QMB is not available for past months or the processing month.

SLMB coverage is available for retro MA months and later months. Note: SLMB is only available for months income exceeds the QMB limit. A person cannot choose SLMB in place of QMB in order for coverage to start sooner (example, to get retro MA).

ALMB coverage is available for retro MA months and later months; however, not for time in a previous calendar year. ALMB is not approved for any month that is in a previous calendar year, even if application was made in the previous calendar year.

The Department will do a determination of eligibility for all other persons. In doing this determination the Department will:

- Explain the nonfinancial eligibility factors. Assume they will be met.
- Use current information to determine financial eligibility. Do not ask for verification.
- Explain that changes may affect the actual determination of eligibility.

The Department must discuss asset policy thoroughly with the Client if the person's assets exceed the limit. Nonfinancial eligibility factors include that the person must be entitled to Medicare Part A. That means something different for QMB than it does for SLMB and ALMB.

For QMB, entitled to Medicare Part A means the person meets condition 1, 2 or 3:

1. Is receiving Medicare Part A with no premium being charged.
2. Refused premium-free Medicare Part A.
3. Is eligible for, or receiving, Premium HI (Hospital Insurance). Premium HI is what the Social Security Administration calls Medicare

For SLMB and ALMB, entitled to Medicare Part A means the person is receiving Medicare Part A with no premium being charged.

An ex parte review is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 calendar days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

Upon review of the applicable law and policy, I have determined the Department improperly denied the Claimant Group 2 benefits and any additional MA benefits the Claimant may have been qualified for. The policy states the Department can only deny Group 2 benefits if the Claimant has not met their assigned deductable in any month in the prior 3 months AND none of the members are QMB, SLMB or ALMB eligible. At the time the Department took action to deny Claimant's Group 2 benefits, it does not appear they made any determination at that time whether or not the Claimant was eligible for QMB, SLMB or ALMB. Therefore, I find it necessary for the Department to initiate a redetermination of the Claimant's eligibility for the different MA programs.

Based on the arguments presented by the Claimant, I find the Claimant's main contention with her FAP benefits was that she believed her child should be included in her group. Because I believe this was the Claimant's sole argument and I have already addressed that issue earlier in this section, I find no need to further address the FAP issue.

DECISION AND ORDER

I find based upon the above findings of fact and conclusions of law, the Department properly budgeted the Claimant's FAP benefits but improperly denied the Claimant's MA.

Therefore, the Department is to initiate a redetermination of the Claimant's MA eligibility beginning July 1, 2011 and award any benefits if otherwise entitled.

It is SO ORDERED.

/s/

Corey A. Arendt
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: September 1, 2011

Date Mailed: September 2, 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 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 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.

CAA/cr

cc: [redacted]