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: 2011-5578
Issue No: 2006
Case No: [redacted]
Load No:
Hearing Date:
January 5, 2011
Oakland County DHS (2)

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 January 5, 2011. Claimant personally appeared and testified.

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA)?

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 2, 2010, the Department of Human Services received a Nursing Home application for claimant.

(2) The verification checklist was sent to claimant with a due date of August 19, 2010. The verification checklist was also sent to her son MPM. W. P.

(3) The checklist requested various documents including the entire annuity contract outlining the terms and conditions.

(4) On August 19, 2010, the department received some of the requested information including a letter from Balic which is the company that holds the annuity.

(5) However, the entire annuity contract was not received as requested.

(6) Therefore, an extension was given and another checklist was mailed on August 19, 2010, requesting the entire annuity contract with a due date of August 26, 2010.

(7) In the interim, a letter from Balic was sent to the Medicaid Policy Unit for evaluation.

(8) Claimant's son contacted the department and requested an extension in an effort to provide the information.

(9) He was given another extension until August 30, 2010.

(10) A letter of confirmation was sent which included another request for the entire annuity.

(11) On August 30, 2010, the claimant received an email from the Medicaid Policy Unit requesting a complete copy of the annuity contract he requested and sent to their attention.

(12) As of August 30, 2010, the department only received another copy of the same letter from [redacted] submitted previously.

(13) Another extension was granted on August 30, 2010, with a due date of September 3, 2010.

(14) However, as of September 7, 2010, the information was not provided and the application was denied.

(15) On September 7, 2010, the department caseworker sent claimant and her son notice that the application was denied for failure to provide verification information.

(16) On September 15, 2010, 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 (BAM), the Program Eligibility Manual (BEM) 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. BAM, Item 105, p. 1.

CLIENT OR AUTHORIZED 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. BAM, 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 BAM 815 and 825 for details. BEM, 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. BEM, Item 260, p. 4.

All Programs

Clients must completely and truthfully answer all questions on forms and in interviews. BAM, 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. BAM, 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. BAM, 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. BAM, 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. BAM, 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. BAM, Item 105, p. 7.

See BAM 220 for processing reported changes.

Other reporting requirements include, but are **not** 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. BAM, 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. BAM, 105, p. 8.

Verifications

All Programs

Clients must take actions within their ability to obtain verifications. DHS staff must assist when necessary. See BAM 130 and BEM 702. BAM, 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. BAM, 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. BEM 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. BAM, Item 130, p. 1.

Verification is usually required at application/redetermination **and** for a reported change affecting eligibility or benefit level. BAM, 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. BAM, 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. BAM, Item 130, p. 2.

The client must obtain required verification, but you must assist if they need and request help. BAM, 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. BAM, 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. BAM, Item 130, p. 4.

Send a negative action notice when:

- the client indicates refusal to provide a verification, **or**
- the time period given has elapsed and the client has not made a reasonable effort to provide it. BAM, Item 130, p. 4.

MA Only

Send a negative action notice when:

- the client indicates refusal to provide a verification, **or**
- the time period given has elapsed. BAM, Item 130, p. 4.

BEM, Item 401, p. 4, indicates that an annuity is a written contract with a commercial insurance company 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. 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 a transfer for less than fair 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, (a person required to be licensed under the laws of the State to sell, solicited or negotiated insurance), and
- is irrevocable, and
- is purchased by an applicant or recipient for Medicaid or their spouse and solely for the benefit of the applicant or recipient or their spouse, and
- is actuarially sound and returns the principle and interest within the annuitants life expectancy, and
- payments must be in substantially equal monthly payments starting with the first payment and continued for the term of the payout with no balloon or lump sum payment, and
- an annuity purchased or amended on or after February 8, 2006, must name the State Of Michigan as the remainder beneficiary or as the second remainder beneficiary after the 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 re-determination.

In the instant case, claimant conceded on the record that he was unable to provide the annuity application/contract which would have indicated the terms of the annuity. Therefore, 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 failed to provide verification information in a timely manner. The department did give claimant the appropriate extensions of time and claimant did not request assistance in gathering the information. Therefore, the department's decision must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has established by preponderance of the evidence that it was acting in compliance with department policy when it determined that claimant's application for Medicaid must be denied based upon the fact that claimant failed to provide verification information in the form of an annuity contract so that the department could determine whether or not claimant's annuity was actuarially sound and whether or not the annuity was revocable.

Accordingly, the department's decision is AFFIRMED.

/s/
Landis Y. Lain
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: February 7, 2011

Date Mailed: February 7, 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 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

cc: [redacted]