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

IN THE MATTER OF:

[redacted]

Reg. No: [redacted]
Issue No: 2014
Case No: [redacted]
Hearing Date:
November 16 2011
[redacted]

ADMINISTRATIVE LAW JUDGE: [redacted]

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 November 16, 2011. Claimant appeared and provided testimony.

ISSUE

Whether the department properly determined Claimant's eligibility for Medical Assistance (MA) benefits?

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 was receiving Ad-Care and Qualified Medicare Beneficiaries medical coverage at all times relevant to this hearing. (Department Hearing Summary)

2. On May 14, 2011, the department notified Claimant that effective June 1, 2011, his Qualified Medicare Beneficiaries (QMB) medical coverage was being closed due to excess income. Claimant was further advised that, effective June 1, 2011, he was eligible for Group 1 Caretaker Relatives Medicaid coverage but was required to pay a deductible in the amount of [redacted]. (Department Exhibit 1).

3. Claimant's household was receiving Retirement, Survivors and Disability Insurance (RSDI) in the amount of [redacted] a month at all times relevant to this hearing.

4. Claimant submitted a hearing request on August 4, 2011, protesting the closure of his QMB coverage. (Request for a 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.

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 Bridges Reference Manual (BRM).

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. Medicaid is also known as Medical Assistance (MA). The local office is responsible for determining a Client's eligibility, calculating their level of benefits and protecting their rights. BAM 105.

Medicare Savings Programs are SSI-related MA categories. They are neither Group 1 nor Group 2. This item describes the three categories that make up the Medicare Savings Programs. The three categories 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 Programs 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 persons 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 the eligibility determination is made. QMB is not available for past months or the processing month.

SLMB coverage is available for retro MA months and later months. 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 a 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.

If a person wishes to know whether MA will pay their Medicare premiums before enrolling in Medicare, that person may contact the Department before reaching age 65 (example, during the three months before the person's 65th birthday). The department may advise persons listed under "Automatic QMB" above that MA will pay their Medicare premium. 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.

In this case, Claimant's Ad-Care and QMB coverage ended as of June 1, 2011, as a result of excess income. Claimant testified that, at the time of closure of this coverage, his household was receiving [redacted] a month in RSDI.

Federal Regulations at 42 CFR 435.831 provide standards for the determination of the Medical Assistance monthly protected income levels. The department, in this case, is in compliance with the Bridges Reference Manual, tables, charts and schedules, table 242. Table 242 indicates that Claimant's monthly protected income level for a person in Claimant's fiscal group in Claimant's situation for a group of 2 is [redacted].

This Administrative Law Judge finds that the department properly determined Claimant's Medicaid eligibility. Once Claimant began receiving RSDI in the amount of [redacted], Claimant was no longer eligible for full coverage Medicaid based on the increased income. The department was then required to determine if Claimant was eligible for Medicaid under any other program. Even though Claimant's net income is in excess of the allowable limits, the department found he is still eligible for Medicaid under the deductible program. As a result, the department properly determined Claimant's Medicaid eligibility.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department properly denied Claimant's eligibility for the Medicaid Qualified Medicare Beneficiaries program due to excess income.

Accordingly, the department's decision is AFFIRMED.

It is SO ORDERED.

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/s/_____
Suzanne Sonneborn
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 11/30/11

Date Mailed: 12/01/11

NOTICE: The Michigan Administrative Hearing System (MAHS) 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. MAHS 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.

SDS/sc

cc: [redacted]