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

IN THE MATTER OF:

[redacted]

Reg. No: 201248683
Issue No: 2026
Case No: [redacted]
Hearing Date: June 6, 2012
Lapeer County DHS

ADMINISTRATIVE LAW JUDGE: Kevin Scully

HEARING DECISION

This matter is before the undersigned Administrative Law Judge by authority of MCL 400.9 and MCL 400.37. The Michigan Administrative Hearing System (MAHS) (Reg. # 201053987) granted the Claimant a hearing and a Decision and Order was issued on January 26, 2011. After a request for a rehearing was denied on March 3, 2011, the Claimant petitioned the Lapeer County Circuit Court for review. On March 26, 2012, the Circuit Court reversed January 26, 2011, decision and remanded the case back to the Michigan Administrative Hearings System (MAHS). After due notice, a telephone hearing was held on June 6, 2012.

ISSUE

Whether the Department of Human Services (Department) provided the Claimant with notice of his Medical Assistance (MA) deductible as required by policy and the effect of submission of bills in a non-chronological order would have on the eligibility determination?

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 January 26, 2012, Administrative Law Judge (ALJ) Kevin Scully issued a Decision and Order in which the ALJ upheld the Department of Human Services (Department) determination of the Claimant's eligibility for Medical Assistance (MA).

2. The Claimant's request for a rehearing was denied on March 3, 2011.

3. On March 26, 2012, the Lapeer County Circuit Court reversed the January 26, 2012, decision and remanded the case back to the Michigan Administrative Hearing System (MAHS).

4. Findings of Fact 1 through 4 (the entire findings) from the January 26, 2012, Decision and Order are hereby incorporated by reference.

5. On February 2, 2010, the Department notified the Claimant that he was approved for Medical Assistance (MA) with a deductible amount of [redacted] with a Notice of Case Action (DHS-1605).

6. On February 2, 2010, the Department sent the Claimant a Deductible Report (DHS-114A) for the Claimant to report medical expenses as required to determine his eligibility for Medical Assistance (MA).

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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), Reference Table Manual (RFT), and the Bridges Reference Manual (BRM).

Clients must cooperate with the local office in determining initial and ongoing eligibility. This includes the completion of necessary forms. BAM 105. Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements. BAM 130. Verification is usually required at application/redetermination and for a reported change affecting eligibility or benefit level when it is required by policy, required as a local office option, or information regarding an eligibility factor is unclear, inconsistent, incomplete, or contradictory. BAM 130. The Department uses documents, collateral contacts, or home calls to verify information. BAM 130. A collateral contact is a direct contact with a person, organization, or agency to verify information from the client. BAM 130. When documentation is not available, or clarification is needed, collateral contact may be necessary. BAM 130.

The Claimant was an ongoing recipient of Medical Assistance (MA). On June 15, 2010, the Department notified the Claimant that that his MA deductible had been met for a benefit period beginning May 22, 2010. The Department then received verification of medical expenses that the Claimant incurred on May 19, 2010. These expenses were not included in the benefit period beginning May 22, 2010.

The Department's applied Bridges Eligibility Manuel (BEM) Item 545, MA Group 2 Income Eligibility, as its authority for not including the May 19, 2010, expenses in the benefit period beginning May 22, 2010. This policy (BEM 545) indicates that a benefit group may report additional expenses that were incurred prior to the MA eligibility date calculated for that month. The Department will not alter the MA eligibility begin date where Medical Assistance (MA) coverage has already been authorized. BEM 545.

Expenses incurred before the eligibility date, but after the first day of that month may apply towards the group's Medical Assistance (MA) benefits, but will be countable as

old bills. Old bills may be applied towards future a future month's deductible where a benefit group is found to have excess income. BEM 545.

The Claimant's representative argued that the Claimant did not receive notice as required by policy, and the Lapeer County Circuit Court remanded the case to determine if the Department gave the Claimant proper notice.

There are two types of written notice defined in Department policy: adequate and timely.

Department policy requires that a notice of case action must specify the following:

- The action(s) being taken by the department.
- The reason(s) for the action.
- The specific manual item which cites the legal base for an action or the regulation or law itself.
- An explanation of the right to request a hearing.
- The conditions under which benefits are continued if a hearing is requested. BAM 220.

An adequate notice is a written notice sent to the client at the same time an action takes effect (not pended). Adequate notice is given in the following circumstances:

- Approval/denial of an application.
- Increase in benefits.
- A recipient or his legal guardian or authorized representative requests in writing that the case be closed.
- Factual information confirms a recipient's death.
- It is verified that a recipient has been approved for assistance in another state.
- It is verified that an eligible child, or in MA, an eligible group member of any age, has been removed from the home as a result of court action.
- Denial of request for medical transportation.
- Case opening with a deductible or patient-pay amount.
- Decrease in post-eligibility patient-pay amount.
- Recipient removed due to his eligible status in another case.

- o Divestment penalty when level of care (LC) code is blank or 20.
- o Addition of MA coverage on a deductible case.
- o Increase in medical benefits. BEM 220.

Timely notice is given for a negative action unless policy specifies adequate notice or no notice. A timely notice is mailed at least 11 days before the intended negative action takes effect. The action is pended to provide the client a chance to react to the proposed action. BEM 220.

In this case, the Department sent the Claimant notice that he had been approved for Medical Assistance (MA) on February 2, 2010, with a deductible of [redacted]. The Department also sent the Claimant a Deductible Report form on February 2, 2010. This approval was for a Medical Assistance (MA) benefit period starting March 1, 2010, and ongoing from that date forward.

This notice was mailed to the Claimant at his correct address of record. The proper mailing and addressing of a letter creates a presumption of receipt. That presumption may be rebutted by evidence. *Stacey v Sankovich*, 19 Mich App 638 (1969); *Good v Detroit Automobile Inter-Insurance Exchange*, 67 Mich App 270 (1976). In this case, the Claimant failed to rebut the presumption of receipt.

This Administrative Law Judge finds that the Claimant received timely notice of his eligibility for Medical Assistance (MA) with a deductible of [redacted].

The Department provided the Claimant notice of his approval for Medical Assistance (MA) with a [redacted] deductible using its standard Notice of Case Action (DHS-1605. This form included the following instructions to the Claimant:

> You meet all of the requirements to receive Medicaid except income. You may become eligible for Medicaid when your allowable expenses are more than your deductible amount. The deductible amount is monthly countable income minus the monthly amount we can allow for living expenses. Your deductible amount or eligibility may change if there are changes in your circumstances, such as changes in income, assets, or family size. Therefore, you must report each change in your circumstances within 10 days of the change.
>
> Enclosed is a form (Deductible Report) for you to list medical expenses as you incur them. List medical expenses you owe that have not been reported. List those expenses no matter how long ago the medical services were provided. When the medical expenses are equal to or more than your deductible amount, return the form to your specialist immediately to determine your eligibility. You may bring the form or proof of incurred medical expenses to the office or

> mail them in. You must bring proof of your income for the last 30 days.
>
> Proof of incurred medical expenses is required. Tell your specialist if you are having trouble getting proof. Examples of proof are current bills, receipts and written statements from your medical care providers. You will not be eligible for Medicaid for any month for which your allowable medical expenses are less than your deductible amount.
>
> For each month that you must incur expenses to become eligible for Medicaid, you have until the last day of the third month following the deductible month to submit your incurred medical expenses. However, the sooner you report and provide proof of your medical expenses, the sooner your eligibility for Medicaid can be determined.

The Department sent the Claimant a Deductible Report (DHS-114A) on February 2, 2010. It is standard practice for the Department to sent Medical Assistance (MA) recipients Medicaid Deductible Information (MDCH PUB-617) along with the Deductible Report, which provides recipients with further information concerning their benefits. This pamphlet is not a dated form, and the Department's representative testified that it does not routinely record when it is sent to benefit recipients.

This Administrative Law Judge finds that the Claimant received adequate notice of his approval for Medical Assistance (MA) benefits and the requirements to submit his medical expenses to the Department to receive benefits.

The Lapeer County Circuit court remanded this case to the Michigan Administrative Hearing System (MAHS) to determine the effect of submission of bills in a non-chronological order would have on the eligibility determination.

In this case, the Department received verification of the Claimant's medical expenses incurred before the eligibility date, but after the first day of that month. The result was that the expenses incurred before the eligibility date took on the classification of old bills. Department policy allows old bills to be applied towards a Medical Assistance (MA) recipient's benefits, but require that they be applied towards future benefit periods. These old bills are not an immediate benefit to the recipient, but are beneficial to MA recipients during months where medical expenses do not exceed the deductible amount.

This Administrative Law Judge finds that the Department properly accounted for the medical expenses incurred by the Claimant and applied them towards his Medical Assistance (MA) benefits in accordance with the applicable Department policies.

It is not within the scope of authority delegated to this Administrative Law Judge to determine whether the Department's policy and procedures concerning the application of a deductible towards a recipient's Medical Assistance (MA) benefits are the most

beneficial to the recipient, or an efficient application of resources. Administrative Law Judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations, or make exceptions to the department policy set out in the program manuals. Furthermore, administrative adjudication is an exercise of executive power rather than judicial power, and restricts the granting of equitable remedies. Michigan Mutual Liability Co. v Baker, 295 Mich 237; 294 NW 168 (1940).

Based on the evidence and testimony available during the hearing, the Department has established that it provided the Claimant with notice of his Medical Assistance deductible as required by policy, and that the effect of submission of bills in a non-chronological order (submitted after the benefit period had been established) was that these medical expenses were properly classified as old bills in accordance with BEM 545.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Department acted in accordance with policy when it provided the Claimant notice of his Medical Assistance (MA) deductible and properly applied his medical expenses towards that deductible.

The Department's Medical Assistance (MA) eligibility determination is **AFFIRMED**. It is SO ORDERED.

/s/

Kevin Scully
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: June 18, 2012

Date Mailed: June 18, 2012

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.

KS/tb

cc: [redacted]