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

IN THE MATTER OF:

[redacted]

Reg. No: 2012-66066
Issue No: 2021
Case No: [redacted]

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 [redacted] Claimant and his spouse appeared and testified. Claimants were represented at the hearing [redacted]

ISSUE

Did the department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA-M) based upon it's determination that claimant had excess assets?

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 [redacted] claimant filed an application for Medical Assistance and Retroactive Medical Assistance for the month of [redacted]

2. On [redacted] the department caseworker set claimant and [redacted] a 3503 Verification checklist.

3. On [redacted] the department caseworker received verifications from the client.

4. Claimants' bank statement lacked daily itemization, so the caseworker contacted claimant [redacted]. who indicated that the statements were not available.

5. On [redacted] the department caseworker processed the application and claimant was found to have excess assets.

6. On [redacted] the department caseworker sent claimant and [redacted] notice that the application was denied because claimants had over $3000 in assets.

7. On [redacted] filed a request for a hearing to contest the department's negative action.

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 or her claim for assistance has been 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 of that decision. 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 Program Administrative Manual (BAM), the Program Eligibility Manual (BEM) and the Program Reference Manual (PRM).

Title XIX of the Social Security Act, commonly referred to as "The Medicaid Act," provides for medical assistance services to individuals **who lack the financial means to obtain needed health care**. 42 U.S.C. §1396. (Emphasis added)

The Medicaid program is administered by the federal government through the Centers for Medicaid and Medicare Services (CMS) of the Department of Health and Human Services (HHS). The state and federal governments share financial responsibility for Medicaid services. Each state may choose whether or not to participate in the Medicaid program. Once a state chooses to participate, it must operate its Medicaid program in accordance with mandatory federal requirements, imposed both by the Medicaid Act and by implementing federal regulations authorized under the Medicaid Act and promulgated by HHS.

Participating states must provide at least seven categories of medical services to persons determined to be eligible Medicaid recipients. 42 USC §1396a(a)(10)(A), 1396d(a)(1)-(5), (17), (21). One of the seven mandated services is *nursing facility services*. 42 USC §1396d(a)(4)(A).

For medical assistance eligibility, the Department has defined an asset as "any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights." NDAC 75-02-02.1-01(3).

Under both federal and state law, an asset must be "actually available" to an applicant to be considered a countable asset for determining medical assistance eligibility. *Hecker,* 527 N.W.2d at 237 (On Petition for Rehearing); *Hinschberger v. Griggs County Social Serv.,* 499 N.W.2d 876, 882 (N.D.1993); 42 U.S.C. § 1396a(a)(17)(B); 1 J. Krauskopf, R. Brown, K. Tokarz, and A. Bogutz, *Elderlaw: Advocacy for the Aging* § 11.25 (2d ed. 1993). Yet, "actually available" resources "are different from those *in hand.*" *Schweiker v. Gray Panthers,* 453 U.S. 34, 48, 101 S.Ct. 2633, 2642, 69 L.Ed.2d 460 (1981) (emphasis in original). NDAC 75-02-02.1-25(2) explains: Only such assets as are actually available will be considered. Assets are actually available when at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the asset available, or to cause the asset to be made available. Assets will be reasonably evaluated···· *See also*45 C.F.R. § 233.20(a)(3)(ii)(D).

As noted in *Hecker,* if an applicant has a legal ability to obtain an asset, it is considered an "actually available" resource. The actual-availability principle primarily serves "to prevent the States from conjuring fictional sources of income and resources by imputing financial support from persons who have no obligation to furnish it or by overvaluing assets in a manner that attributes non-existent resources to recipients." *Heckler v. Turner,* 470 U.S. 184, 200, 105 S.Ct. 1138, 1147, 84 L.Ed.2d 138 (1985).

The focus is on an applicant's actual and practical ability to make an asset available as a matter of fact, not legal fiction. *See Schrader v. Idaho Dept. of Health and Welfare,* 768 F.2d 1107, 1112 (9th Cir.1985). *See also Lewis v. Martin,* 397 U.S. 552, 90 S.Ct. 1282, 25 L.Ed.2d 561 (1970) (invalidating California state regulation that presumed contribution of non-AFDC resources by a non-legally responsible and non-adoptive stepfather or common law husband of an AFDC recipient's mother).

Determining whether an asset is "actually available" for purposes of medical assistance eligibility is largely a fact-specific inquiry depending on the circumstances of each case. *See, e.g., Intermountain Health Care v. Bd. of Cty. Com'rs,* 107 Idaho 248, 688 P.2d 260, 264 (Ct.App.1984); *Radano v. Blum,* 89 A.D.2d 858, 453 N.Y.S.2d 38, 39 (1982); *Haynes v. Dept. of Human Resources,* 121 N.C.App. 513, 470 S.E.2d 56, 58 (1996). Interpretation of the "actually available" requirement must be "reasonable and humane in accordance with its manifest intent and purpose····" *Moffett v. Blum,* 74 A.D.2d 625, 424 N.Y.S.2d 923, 925 (1980). That an applicant must sue to collect an asset the applicant has a legal entitlement to usually does not mean the asset is actually unavailable. *See, e.g., Wagner v. Sheridan County S.S. Bd.,* 518 N.W.2d 724, 728 (N.D.1994); *Frerks v. Shalala,* 52 F.3d 412, 414 (2d Cir.1995); *Probate of Marcus,* 199 Conn. 524, 509 A.2d 1, 5 (1986); *Herman v. Ramsey Cty. Community Human Serv.,* 373 N.W.2d 345, 348 (Minn.Ct.App.1985). *See also Ziegler v. Dept. of Health & Rehab. Serv.,* 601 So.2d 1280, 1284 (Fla.Ct.App.1992) At issue here is the methodology utilized in determining the availability of an individual's "resources" for purposes of evaluating his or her eligibility. SSI recipients, and thus SSI-related "medically needy"

recipients, may not retain resources having a value in excess of $2,000. 42 U.S.C. § 1382(a)(1)(B).

The regulations governing the determination of eligibility provide that resources mean cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).20 C.F.R. § 416.1201(a).

- Assets must be considered in determining eligibility or SSI related categories. Assets mean cash, any other personal property and real property. (BEM, Item 400 Page 1). Countable assets cannot exceed the applicable asset limit. Not all assets are counted. Some assets are counted for one program but not for another program. (BEM Item 400, Page 1). The department is to consider both of the following to determine whether and how much of an asset is countable: An asset is countable if it meets the availability test and is not excluded. The department is to consider the assets of each person in the asset group. (BEM, Item 400, Page 1). Asset eligibility exists when the asset groups countable assets are less than or equal to the applicable asset limit at least one day during the month being tested. (BEM, Item 400, Page 4). An application does not authorize MA for future months if the person has excess assets on the processing date. The SSI related MA asset limit for SSI related MA categories that are not medicare savings program or QDWI is $2000.00 for an asset group for one person and $3000.00 for an asset group of 2 people. BEM, Item 400 Page 5. An asset must be available to be counted. Available means that someone in the asset group has the legal right to use or dispose of the asset. BEM, Item 400, Page 6. The department is to assume an asset is available unless the evidence shows that it is not available. Availability might be affected by joint ownerships and efforts to sell or the possibility of domestic violence. BEM, Item 400, Page 6.

In the instant case, the department has established by the necessary competent, material and of substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant had in excess of $3000.00 in countable available assets because the cash value when added to claimant's assets resulted in more than $3000 in countable available assets for claimant. The department's case must be upheld.

The claimant's representative did present itemized bank account statements to the Administrative Law judge on [redacted] at the hearing. However, claimants had ample opportunity to present the documents at the time of application and thereafter.

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

Allow the client 10 calendar days (or other time limit specified in policy) to provide the verification you request. Refer to above policy for citizenship verifications. If the client cannot provide the verification despite a reasonable effort, extend the time limit up to three times. Verifications are considered to be timely if received by the date they are due. For electronically transmitted verifications (fax, email), the date of the transmission is the receipt date. Verifications that are submitted after the close of regular business hours through the drop box or by delivery of a DHS representative are considered to be received the next business day.

Send a case action notice when:

- The client indicates refusal to provide a verification, **or**
- The time period given has elapsed. BAM, Item 130, pps. 4-5.

Claimant stated that they did not have itemized statements to provide. The department appropriately made the determination with available information. Claimants or their representative could even have filed a second application for the requisite months since they were actually able to acquire the documents at a later date. Claimants' did not request an extension of time or provide the documents and indicated to the caseworker that itemized daily statements were not available. The department used the best available information to make its determination at the time of application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the claimant has in excess of $3000.00 in countable available assets for purpose of medical assistance benefit eligibility. The department properly denied claimants' application for Medical Assistance under the circumstances in determining that claimant had excess countable available assets.

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: [redacted]

Date Mailed: [redacted]

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/jk

cc: [redacted]
MAHS