STATE OF MICHIGAN

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

IN THE MATTER OF:

Register No.: 2013-40893
Issue No.: 2019
Case No.:
Hearing Date: June 18, 2013
Allegan County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

AMENDED HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the claimant's request for a hearing. After due notice, an in-person hearing was held on June 18, 2013. Claimant died November 11, 2010. Claimant's spouse and daughter appeared to testify on claimant's behalf. Claimant was represented at the hearing by (The department as represented at the hearing by Assistant Attorney General). Assistance Payments Supervisor Long Term Care Specialist and Medicaid Specialist appeared to testify on the department's behalf.

ISSUE

Did the Department of Human Services (the department or DHS) properly determine that claimant must use third Party resources in addition to claimant's Patient Pay Amount for payment of nursing home fees?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds a material fact:

(1) On May 29, 2009, a Medical Assistance (MA) Long Term Care (LTC) application was filed on behalf of claimant.

(2) The department determined that claimant was eligible for Medical Assistance Long Term Care with a Patient Pay Amount.

(3) Subsequent to determination of Patient Pay Amount, the department discovered that claimant was receiving LTC insurance in the amount of approximately $ per month.

(4) On August 18, 2009, the department sent claimant notice of his patient pay amount.

(5) On March 29, 2010, claimant's representative filed a request for a hearing to contest the department's determination that the LTC payments received from a private insurer must be paid by claimant to the nursing home, in addition to the Patient Pay Amount.

(6) Claimant died November 11, 2010.

(7) Claimant has an outstanding bill from the nursing home for the time period from January 1, 2009 through December 31, 2010.

(8) The parties stipulate that the Patient Pay Amount is not in dispute in this case.

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 Bridges Administrative Manual (BAM), the Bridges 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).

Unless otherwise provided by federal law, Medicaid is considered to be the payor of last resort. *See Wesley Health Care Ctr., Inc. v. DeBuono,* 244 F.3d 280, 281 (2d Cir.2001); S.Rep. No. 99-146, 280, 99th Cong., 1 st Sess. 312 (Oct. 2, 1985). This means that all other available resources must be used before Medicaid pays for the medical care of an individual enrolled in a Medicaid program.

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)*.

Michigan Department of Human Services policy states in pertinent part:

As a condition of eligibility, the client must identify all third-party resources unless he has good cause for not cooperating. Failure, without good cause, to identify a third-party resource results in disqualification.

A third-party resource is a person, entity or program that is, or might be, liable to pay all or part of a group member's medical expenses.

The Third Party Liability Division, Bureau of Financial Management, in the Department of Community Health uses third-party resource information to reduce MA expenditures by both:

- Rejecting MA claims until liable third-parties have paid.
- Seeking reimbursement from liable third-parties after MA payment has been made. BEM, Item 257, page 1.

Usually, the resource is Medicare or a health/casualty insurance company. Resources often exist in the following situations:

- A person has private health insurance.
- Work-related injury.
- An injury occurs outside the home (for example: an auto accident).
- Other accident/incident resulting in illness or injury (for example: crime, medical malpractice, slip and fall, faulty product).

LTC insurance (for example: Cigna, John Hancock, AFLAC, Conseco). BEM, Item 257, page 1.

Current Medical Assistance policy dictates that insurance payments that are specifically made as reimbursement for incurred medical expenses are excluded as income and as assets.

Common sources of such payments are:

- Health insurance; see BPG glossary.
- Automobile insurance that covers medical expenses.
- Long term care facility insurance.

Other insurance must pay claims for medical expenses before MA. See BEM 257, Third Party Resource Liability, for reporting insurance coverage using the DCH 0078, Request to Add, Terminate or Change Other Insurance. BEM, Item 503, page 16

BEM, Item 546, is the item used to determine post eligibility patient pay amounts (PPA's). A post eligibility PPA is the L/H patient share of their cost of long term care or hospital services. The department is to first determine MA eligibility. Then the department is to determine the post eligibility to patient pay amount when MA eligibility exists for L/H patient's eligible under an SSI related Group 1 or Group 2 category. MA income eligibility and post eligibility patient pay amount determinations are not the same. Countable income and deductions from income are often different. Medical expenses, specific costs of long term care, are never used to determine a post eligibility patient pay amount. The department does not recalculate the patient pay amount for the month of death. The post eligibility patient pay amount is total income minus total need. Total income is the client's countable unearned income plus its remaining earned income. Total need is the sum of the following when allowed by later sections of this item: patient allowance, community spouse, income allowance, family allowance, children's allowance, health insurance premiums, and guardianship/conservator expenses. BEM, Item 546, p. 1. The aforementioned are the only allowances and expenses used in the consideration of a Patient Pay Amount. Department policy does not allow third party LTC insurance payments to be deducted from the patient pay amount.

In the instant case, the facts indicate that claimant's Patient Pay Amount was determined to be $ per month. (Department Exhibit #19, originally numbered as #24) It was changed once claimant provided a letter of Intent to Contribute Income which indicated that claimant did not intend to make any money available to his spouse, and that claimant intended to, make on $0 of the Community Spouse Allowance available to his spouse each month. (Department Exhibit 18, originally numbered as #23) The Patient Pay Amount was changed to $ on the Patient Pay Amount budget dated May 12, 2010. (Department Exhibit 20 originally numbered as #25). The parties agree that the Patient Pay Amount is not in dispute. Thus, claimant retained the responsibility to pay the Patient Pay Amount at all times relevant to his stay in the nursing home, based upon his income and available assets.

Claimant's representative argues that claimant received the private LTC insurance payment and paid the monies directly to the nursing home (approximately $[redacted] per month) as the Patient Pay Amount. Claimant's representative also argues that current Medical Assistance policy dictates that insurance payments that are specifically made as reimbursement for incurred medical expenses are excluded as income and as assets. Lastly, the claimant's representative contends that claimant should not also have to pay additional monies to the nursing home and that claimant should not be responsible for the outstanding bill of approximately $[redacted] in unpaid fees incurred from claimant's nursing home stay from January 1, 2009 through December 31, 2010. Claimant's position is that he has been penalized for purchasing LTC insurance, and is no better off having purchased it than if he had never done so.

Claimant acknowledged his responsibility to turn over any third party benefits in the application for benefits. The benefit application, signed either by claimant or his legal representative, on May 29, 2009, specifically states:

> Assignment of Benefits
>
> **Recovery of Medical Costs**. I understand that then the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan – MDCH (Administrative Law Judge (ALJ) Exhibit 2-5)

This Administrative Law Judge determines that claimant retained the responsibility to pursue potential resources. In this case, claimant purchased LTC insurance specifically to help defray the cost of nursing home care. Policy does dictate that claimant's LTC payments from a private insurer are not counted as an asset or as income <u>when</u> they are used to pay claimant's medical expenses. (Under both the policy in effect in 2009 and 2013). However, policy does not state that if claimant uses private insurance to help defray the cost of long term care that the Patient Pay Amount no longer has to be paid. 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, Item 105, page 1. Medicaid is first and foremost a program for persons who meet certain categorical, income and asset standards.

The Social Welfare Act, MCL 400.105(1) provides Medical Assistance to the "medically indigent." MCL 400.106 (1)(b) states:

> (ii) The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or resources of the patient. The state department is subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician

> services, nursing services, and other medical services not to exceed the amount of funds expended by the state department for the care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department.

The Michigan Department of Community Health Medicaid Provider Manual explicitly states:

> Section 1.1 When a beneficiary has a third party resource available, Medicaid has the legal right to subrogation…To be eligible for Medicaid, beneficiaries must assign, to MDCH, the right to collect other insurance payments on their behalf.

Those persons who retain sufficient resources must use those resources to pay for their own medical care in the event that they must enter Long Term Care before Medicaid will pay. Current Medical Assistance policy dictates that insurance payments that are specifically made as reimbursement for incurred medical expenses are excluded as income and as assets. Therefore, the LTC insurance payments must be made as reimbursement for incurred medical expenses or the LTC insurance payments would count as income or assets when determining the Patient Pay Amount. Third party payments are completely separate from the Patient Pay Amount. The Patient Pay Amount was determined from claimant's assets and income; exclusive of the LTC insurance payments as long as the LTC insurance payments were paid for direct reimbursement of incurred medical expenses. The Patient Pay Amount determination did not at any time include the LTC insurance payments as a countable asset or income. A third party LTC payment which was not used for direct reimbursement of medical services is a separate asset or income, just as the proceeds of a bank account and an annuity would be counted as a separate asset or income to the person who was legally entitled to the funds. Thus, the department appropriately determined that claimant must use his third party LTC insurance as a resource to defray the cost of his nursing home care. The Department also properly determined that claimant continued to be responsible to pay his Patient Pay Amount which was appropriately calculated exclusive of the LTC insurance payments, in accordance with department policy. There has been no negative action in this case.

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 the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it decided that the department appropriately determined that claimant must use his LTC insurance as a resource to defray the cost of his nursing home care. The Department also properly determined that claimant continued to be responsible to pay his Patient Pay Amount which was appropriately calculated in accordance with department policy.

Accordingly, the department's decision is AFFIRMED.

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

Date Signed: June 26, 2013

Date Mailed: June 26, 2013

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 of the rehearing decision.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at
Michigan Administrative Hearings
Reconsideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

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