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

IN THE MATTER OF:

[redacted]

Reg. No: 201317994
Issue No: 2026
Case No: [redacted]
Hearing Date: May 15, 2013
County: Mason

ADMINISTRATIVE LAW JUDGE: C. Adam Purnell

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 received on December 4, 2012. After due notice, a telephone hearing was held on May 15, 2013. Claimant personally appeared and provided testimony. Participants on behalf of the Department included [redacted] (Assistance Payments Worker) and [redacted] (Assistance Payments Supervisor).

ISSUE

Whether the Department properly processed Claimant's medical expenses for purposes of her Medical Assistance (MA) deductible or "spend down"?

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, at all times, had a MA deductible in the amount of $227.00.

2. On July 30, 2012, Claimant provided the Department with several medical bills, but the bills did not meet the deductible amount.

3. The Department then accepted an additional medical bill with a July 25, 2012 date of service and used this bill to meet Claimant's deductible.

4. On or about September 25, 2012, Claimant provided the Department with additional medical bills from July 2012 and requested the Department use these bills toward her deductible.

5. On October 10, 2012, the Department mailed Claimant a Notice of Case Action (DHS-1605) and returned the additional medical bills to Claimant because she had already met her deductible for July 2012.

6. On December 4, 2012, Claimant submitted a hearing request protesting the Department's refusal to move her deductible met date from July 25, 2012 to July 7, 2012.

CONCLUSIONS OF LAW

The client has the right to request a hearing for any action, failure to act or undue delay by the department. BAM 105. The department provides an administrative hearing to review the decision and determine its appropriateness. BAM 600.

The regulations that govern the hearing and appeal process for applicants and recipients of public assistance in Michigan are contained in the Michigan Administrative Code (Mich Admin Code) Rules 400.901 through 400.951. An opportunity for a hearing shall be granted to a recipient who is aggrieved by an agency action resulting in suspension, reduction, discontinuance, or termination of assistance. Mich Admin Code 400.903(1).

The Medical Assistance (MA) program was established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The department administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies for the MA programs are contained in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), the Bridges Reference Manual (BRM), and the Reference Tables Manual (RFT).

The MA program is also referred to as "Medicaid." BEM 105. 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 105. The Medicaid program is comprised of several sub-programs or categories. One category is FIP recipients. BEM 105. Another category is SSI recipients. BEM 105. There are several other categories for persons not receiving FIP or SSI. BEM 105. However, the eligibility factors for these categories are based on (related to) the eligibility factors in either the FIP or SSI program. BEM 105. Therefore, these categories are referred to as either FIP-related or SSI-related. BEM 105.

To receive Medicaid under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant women, receive Medicaid under FIP-related categories. For MA only, a client and the client's community spouse have the right to request a hearing on an initial asset assessment only if an application has actually been filed for the client. BAM 105. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. BEM 105.

For purposes of MA in general, the terms Group 1 and Group 2 relate to financial eligibility factors. BEM 105. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. BEM 105. The income limit, which varies by category, is for nonmedical needs such as

food and shelter. BEM 105. Medical expenses are not used when determining eligibility for FIP-related and SSI-related Group 1 categories. BEM 105. For Group 2, eligibility is possible even when net income exceeds the income limit. BEM 105. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories. BEM 105.

Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred. BEM 545. Periods of MA coverage are added each time the group meets its deductible. BEM 545. **Each calendar month is a separate deductible period. BEM 545.** The first deductible period cannot be earlier than the processing month for applicants and is the month following the month for which MA coverage is authorized for recipients. BEM 545.

According to policy, the fiscal group's monthly excess income is called a deductible amount. BEM 545. **Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month tested. BEM 545. The group must report expenses by the last day of the third month following the month in which the group wants MA coverage. BEM 545.** Department policy BAM 130 explains verification and timeliness standards. BEM 545.

The department is authorized to close an active deductible case when any of the following occur: (1) no one in the group meets all nonfinancial eligibility factors; (2) countable assets exceed the asset limit or (3) the group fails to provide needed information or verification. BEM 545.

The department is instructed to add periods of MA coverage each time the group meets its deductible. BEM 545. The department will redetermine MA eligibility for active deductible cases at least every 12 (twelve) months unless the group has not met its deductible within the past three months. BEM 545. If a group has not met its deductible in at least one of the three calendar months before that month and none of the members are QMB, SLM or ALM eligible, Bridges will automatically notify the group of closure. BEM 545.

The group must report changes in circumstances within 10 days. BEM 545. The Department is instructed to review the group's eligibility when a change that may affect eligibility is reported. BEM 545. Then, the Department may apply changes for the corresponding period as follows if MA coverage has been authorized. BEM 545. But the **Department may never reduce MA coverage already authorized on Bridges for the processing month or any past month. BEM 545.**

BEM 545 does not permit the Department to alter the MA eligibility begin date if he or she has already authorized coverage on Bridges. BEM 545. However, any expenses the group reports that were incurred from the first of such a month through the day before the MA eligibility begin date might be countable as old bills. BEM 545.

BEM 545 provides several examples to instruct Department workers how to proceed when a client reports medical expenses for purpose of an MA deductible. The instant matter is similar to BEM 545 Example 7 which illustrates when expenses are reported

after MA coverage is added, listed on pages 23 and 24. This example provides as follows, “Mr. C. has a $55.00 deductible amount. 10/7/01 - Mr. C. reports the following allowable medical expenses: 10/1/01 Dentist for filling - $37.50; and 10/6/01 Outpatient blood test - $52.00; 10/14/01 - Authorize full MA coverage effective 10/6/01 with Mr. C's liability= $17.50. 10/28/01 - Mr. C. verifies the following additional allowable medical expenses: 10/2/01 Specialist exam - $75.00; 10/2/01 Prescription - $18.75. Determine that the specialist exam is unpaid. However, Mr. C. paid for the prescription. Coverage cannot be backdated to an earlier date in 10/01. Therefore, you complete a budget on Bridges for 11/01, counting the $75.00 expense as an old bill. The paid prescription cost cannot be counted. Mr. C. meets his deductible for 11/01, based on the $75.00 old bill. $20.00 remains as an unused old bill. Authorize MA coverage for 11/1/01 through 11/30/01 and send Mr. C. a DHS-4598, DHS-114 and DHS-114A.”

Pursuant to BAM 600, the Administrative Law Judge determines the facts based only on evidence introduced at the hearing, draws a conclusion of law, and determines whether DHS policy was appropriately applied. BAM 600. The ALJ issues a final decision unless the ALJ believes that the applicable law does not support DHS policy or DHS policy is silent on the issue being considered. BAM 600. In that case, the ALJ recommends a decision and the policy hearing authority makes the final decision. BAM 600.

Here, the Department workers who attended this hearing are actively assisting Claimant with her MA deductible issue. The underlying issue is as follows: the Department initially processed and certified Claimant’s MA medical bills after she met her $227.00 MA deductible using prescription medical bills dated July 25, 2012. Later, in August 2012, Claimant received additional medical bills for services provided earlier on July 7, 2012. Claimant forwarded these additional July 7, 2012 medical bills to the Department in an attempt to change her MA deductible certification date from July 25, 2012 to July 7, 2012. The Department made a request for “application support” to move Claimant’s deductible met date back to July 7, 2012, but the request was denied “due to policy.” The Department, and presumably Claimant as well, contends that Claimant should be permitted to change the MA deductible certification date from July 25 to July 7 as it was within the 90 days allowed to submit medical bills for a targeted month.

The Administrative Law Judge does not believe that applicable law fails to support policy or that policy is silent on the issue being considered. Claimant simply disagrees with the manner in which BEM 545 is being executed by the Department. This Administrative Law Judge finds that the specific language of BEM 545 controls. The Department may not use Claimant’s old bills from July 7, 2012 toward the July deductible because the bills were already certified on July 25, 2012. Therefore, based on the material, competent and substantial evidence, this Administrative Law Judge finds that the Department properly determined Claimant’s MA eligibility because Claimant’s MA deductible had been met and certified using July 25, 2012.

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 in determining the initial date that Claimant's MA deductible was met.

The Department's MA eligibility determination is **AFFIRMED**.

IT IS SO ORDERED.

/s/_____
C. Adam Purnell
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: May 20, 2013

Date Mailed: May 21, 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 date of the rehearing decision.

CAP/aca

cc: [redacted]