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

IN THE MATTER OF:

[redacted]

Reg. No.: 2014-32928
Issue No(s).: 2008
Case No.: [redacted]
Hearing Date: April 24, 2014
County: Oakland-03

ADMINISTRATIVE LAW JUDGE: Darryl T. Johnson

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a three-way telephone hearing was held on April 24, 2014, from Lansing, Michigan. Participants on behalf of Claimant included the Claimant and her Designated Hearing Representative [redacted]. Participants on behalf of the Department of Human Services (Department) included Family Independence Manager [redacted] Eligibility Specialist [redacted], and observer [redacted].

ISSUE

Did the Department properly deny payment of Claimant's Medicaid (MA) expense?

FINDINGS OF FACT

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

1. Claimant applied for MA and retroactive MA on May 28, 2013, through [redacted] ([redacted] &[redacted]

2. Claimant was approved for MA Group 2 Caretaker for the month of February 2013, with a $[redacted] deductible. (Exhibit 1 Page 6.)

3. Claimant incurred medical expenses at [redacted] in the amount of $[redacted] during February 2014, and the [redacted] paid that expense as "Full Uncompensated Care" on July 26, 2013. (Exhibit 1 Page 10.)

4. On June 30, 2013, [redacted] asked the Department, on behalf of [redacted], for assistance in paying Claimant's medical bills. (Exhibit 1 Page 20.)

5. Because the outstanding balance on Claimant's account was $0, the Department has not paid anything.

6. Claimant, through [redacted] requested a hearing on March 12, 2014.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), Department of Human Services Reference Tables Manual (RFT), and Department of Human Services Emergency Relief Manual (ERM).

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105.

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. Medicaid is also known as Medical Assistance (MA).

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

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.

Clients may qualify under more than one Medicaid category. Federal law gives them the right to the most beneficial category. The most beneficial category is the one that results in eligibility or the least amount of excess income. BEM 105.

The State of Michigan has set guidelines for income, which determine if a Medicaid group is eligible. Income eligibility exists for the calendar month tested when there is no excess income, or allowable medical expenses equal or exceed the excess income (under the Deductible Guidelines). BEM 545.

Net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. BEM 105. Income eligibility exists when net income does not exceed the Group 2 needs in BEM 544. BEM 166. The protected income level is a set allowance for non-medical need items such as shelter, food and incidental expenses. RFT 240 lists the Group 2 Medicaid protected income levels based on shelter area and fiscal group size. BEM 544. An eligible Medicaid group (Group 2 MA) has income the same as or less than the “protected income level” as set

forth in the policy contained in the Reference Table (RFT). An individual or Medicaid group whose income is in excess of the monthly protected income level is ineligible to receive Medicaid.

A Medicaid group with excess income may become eligible for assistance under the deductible program. The deductible program is a process which allows a client with excess income to be eligible for Medicaid, if sufficient allowable medical expenses are incurred. Each calendar month is a separate deductible period. The fiscal group's monthly excess income is called the deductible amount. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month. The Medicaid group must report expenses by the last day of the third month following the month it wants medical coverage. BEM 545; 42 CFR 435.831.

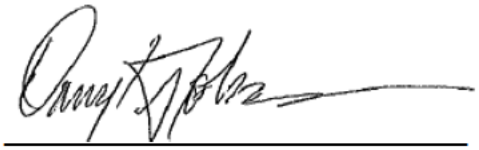
Claimant does not dispute the deductible established by the Department. The issue here centers on the statement by [redacted] that the [redacted] has rescinded the Full Uncompensated Care payment as of [redacted] (Exhibit 1 Page 14.) The [redacted] did not participate in the hearing. No one from [redacted] participated in the hearing. The available evidence establishes that the Claimant's medical expenses were paid and, at least as of [redacted], [redacted] is reporting that the expenses are not paid.

This is an issue of first impression for the undersigned. As stated above, this is not an issue of whether the Department properly determined Claimant's eligibility for MA, or set an appropriate deductible. The issue is whether the Department is to pay for medical expenses incurred during a period of eligibility when the expenses were reportedly paid by a third party. The Claimant and her AHR acknowledge that the bill was paid initially. I find that the burden is on the Claimant to establish that the bill remains unpaid. That burden has not been met.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds that the Department acted in accordance with Department policy when it denied payment of the medical expenses from February 2013.

DECISION AND ORDER

Accordingly, the Department's decision is **AFFIRMED**.



Darryl T. Johnson
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: April 30, 2014

Date Mailed: April 30, 2014

NOTICE OF APPEAL: 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 or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

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 90 days of the filing of the original request (60 days for FAP cases).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-07322

DTJ/las

cc: [redacted]