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

IN THE MATTER OF:

[redacted]

Reg. No.: 2014-36159
Issue No(s).: 2008
Case No.: [redacted]
Hearing Date: April 24, 2014
County: Oakland-03

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

RECONSIDERATION 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 Administrative Hearings Representative (AHR) [redacted] Participants on behalf of the Department of Human Services (Department) included Family Independence Manager [redacted], Eligibility Specialist [redacted]

The original hearing, [redacted], was held by Administrative Law Judge [redacted]. This Reconsideration Hearing Decision and Order was completed by Administrative Law Judge [redacted] after considering the entire record.

ISSUE

Did the Department of Human Services (Department or DHS) properly fail to take action when Claimant requested payment of Claimant's Medical Assistance (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. On May 28, 2013, Claimant applied for MA and retroactive MA, through [redacted] Associates ([redacted]).

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

3. On [redacted], the Department caseworker sent Claimant and [redacted] a Notice of Case Action (DHS-1605) that her application was approved.

4. Claimant incurred medical expenses at [redacted] in the amount of $[redacted] during [redacted], and the [redacted] paid that expense as '[redacted]'. (Exhibit 1 Page 10.)

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

6. On [redacted] statement was submitted to the Department showing a Claimant liability of $[redacted] and that the Medical expense was covered by Full Uncompensated Care.

7. Because the outstanding balance on Claimant's account was $[redacted] the Department took no action.

8. On [redacted] submitted a statement to the Department which showed an expense of $[redacted] for a service date of [redacted]. The statement showed a zero dollar Claimant liability because of a [redacted]

9. The Department determined that [redacted] with the service date of [redacted], were not a countable medical expense. No action was taken.

10. On March 12, 2014, Claimant, through [redacted] filed a request for a hearing.

11. Claimant and her AHR acknowledged/conceded on the record that the bill was paid initially.

12. On [redacted], Administrative Law [redacted] issued a Decision and Order Affirming the Department's action to deny payment of Claimant's [redacted].

13. On May 29, 2014, [redacted] filed a request for rehearing/reconsideration based upon misapplication of law or policy and stated that the Administrative Law Judge erred in finding that the Department acted in accordance with Department policy when it [redacted] from [redacted]

14. On [redacted] 4, Supervising Administrative Law Judge [redacted], stating that Claimant's authorized hearings representative has articulated sufficient grounds to support a request for reconsideration of the Administrative Law Judge's hearing decision.

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). Claimants 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 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.

MAHS (DHS) may grant a hearing about any of the following:

- Denial of an application and/or supplemental payments.
- Reduction in the amount of program benefits or service.
- Suspension or termination of program benefits or service.
- Restrictions under which benefits or services are provided.
- Delay of any action beyond standards of promptness.
- For **FAP only**, the current level of benefits or denial of expedited service.
- MA Only

MAHS (DHS) may grant a hearing about any of the following:

- Community spouse income allowance.
- Community spouse's income considered in determining the income allowance.
- Initial asset assessment (but only if an application for MA has actually been filed for the Claimant).
- Determination of the couple's countable assets or protected spousal amount.
- Community spouse resource allowance. BEM 600, pages 4-5

A **rehearing** is a full hearing which is granted when either of the following occurs:

- The original hearing record is inadequate for purposes of judicial review.

- There is newly discovered evidence **that existed** at the time of the original hearing that could affect the outcome of the original hearing decision.

A **reconsideration** is a paper review of the facts, law and any new evidence or legal arguments. It is granted when the original hearing record is adequate for purposes of judicial review and a rehearing is **not** necessary, but one of the parties believes the ALJ failed to accurately address all the relevant issues **raised in the hearing request**. BEM 600, page 42.

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.

Claimants 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 Claimant 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] has rescinded the Full Uncompensated Care payment as of [redacted]. (Exhibit 1 Page 14.) The Department of Community Health (MDCH) 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 that, at least as of [redacted] is reporting that the expenses are not paid.

Pertinent Department policy dictates that MDCH determinations include all of the following:

- Denial of prior authorization.
- **Denial of payment for a service, appliance or prosthesis**. (Emphasis Added)
- Restricted utilization of the Claimant's mihealth card.
- Determination of level of care (long-term care or MIChoice waiver).
- Enrollment in managed care, including requests for exemption.
- Denial of CHILD's waiver services.
- Determining MIChild eligibility.
- Reduction of services.
- Authorization of MA for a newborn under BEM 145. BEM 600, page 14.

As stated above, this case does not involve an issue of whether the Department properly determined Claimant's eligibility for MA, or set an appropriate deductible. The Department of Human Services (DHS) has jurisdiction to make only eligibility determinations. DHS does not retain jurisdiction to determine whether or not the denial of a payment for service was appropriately made.

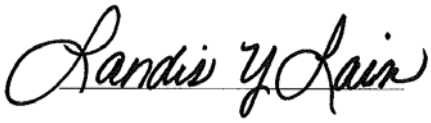
The issue in this case is whether the Department is to pay for medical expenses incurred during a period of eligibility when the expenses were reportedly paid by a third

party. The Claimant and her AHR acknowledge that the bill was paid initially. This Administrative Judge finds that Department policy dictates that the Department of Community Health (MDCH) makes determination for the denial of a payment for a service. The Department of Human Services (DHS) is not the appropriate agency/Department to hear or make a determination on the instant issue. The Claimant or her AHR should have filed the initial request for hearing and the request for rehearing/reconsideration with MDCH for determination on this issue.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, finds under the circumstances that DHS is not the appropriate venue to assert this issue and that the request for reconsideration/rehearing must be **DISMISSED** for lack of jurisdiction.

DECISION AND ORDER

Accordingly, the Claimant's request for DHS hearing on this issue is **DISMISSED** for lack of jurisdiction.



Landis Y. Lain
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: 10/23/14

Date Mailed: 10/23/14

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 Claimant;
- 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

LYL/tb

cc: [redacted]