STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARINGS SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF: **Docket No.** 14-007088 MSB

Appellant
_______________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon Appellant's request for a hearing.

After due notice, a hearing was held on appeared on Appellant's behalf. , Assistant Attorney General, represented the Department. Medicaid Analyst with the PEME Program and , Policy Specialist in the Medical Services Administration appeared as witnesses for the Department.

ISSUE

Did the Department properly deny Appellant's request for a Pre-Eligibility Medical Expense offset (PEME)?

FINDINGS OF FACT

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

1. Appellant is a -year old Medicaid beneficiary, born (Exhibit 1, p. 2 and Bridges).

2. On , Appellant applied for Medicaid and was approved retroactive to . On , Appellant's Medicaid case closed. On , Appellant again applied for Medicaid and was approved retroactive to . (Exhibit 1, p. 2, and testimony).

3. On a DHS-0035 LTC Medicaid Re-determination Notice was sent to (Exhibit A, pp. 1, 3).

4. On , a DHS-1605 Client Action Notice was sent to the Appellant via notifying him that his Medicaid case would close effective for failure to return the necessary

paperwork for the required redetermination. (Exhibit A, pp. 1, 5 and testimony).

5. On , Appellant's Medicaid case closed again due to the failure to return the necessary paperwork for the required first redetermination. (Exhibit A, pp. 1, 5 and testimony).

6. Appellant incurred expenses in his long term care facility from through in the amount of 1. (Exhibit A, p. 1, Exhibit 1, p. 2 and testimony).

7. On , Appellant again applied for Medicaid and was approved retroactive to . Medicaid coverage was denied for through due to excess assets. (Exhibit A, p. 2, Exhibit 1, p. 2 and testimony).

8. On Appellant requested Pre-Eligibility Medical Expense (PEME) offset for the balances incurred from through . (Exhibit A, p. 1, Exhibit 1, p. 2 and testimony).

9. On , the Department denied Appellant's request for PEME offset. Written notification was sent to Appellant's attorney stating: "Beneficiary does not qualify for PPA offset. Request and medical expenses must be reported prior to the first Medicaid redetermination following the initial eligibility." (Exhibit A, p. 1, 4 and testimony).

10. On , Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1).

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program. The State Plan states in part:

> ***Reasonable Limits on Amounts for Necessary Medical or Remedial Care not Covered under Medicaid***
>
> Reasonable and necessary medical expenses not covered by Medicaid, incurred in the 3 month period prior to the month of application are allowable deductions. Expenses incurred prior to this three month period are not allowable deductions. [Supplement 3 to Attachment 2.6-A, p. 1, Effective 7/1/2009].

Medicaid eligibility is a responsibility of the Department of Human Services through a contract with the Department of Community Health.

Policy covering a Pre-Eligibility Medical Expense (PEME) offset is contained in the Bridges Eligibility Manual, BEM 164, pp. 2-3 of 4, 10-1-2014 and BEM 546, 10-11, 7-1-2014. BEM 164 states in part:

> **Patient Pay Offsets**
>
> If an LTC applicant requests an offset of their patient pay to cover old medical bills, see Pre-Eligibility Medical Expense (PEME) in glossary and in this item. Assist the applicant by forwarding their unpaid bills to:
>
> Medical Services Administration
> Michigan Department of Community Health
> P.O. Box 30479
> Lansing, MI 48909-9634
> Attn: PEME
>
> DCH will determine whether an offset is allowable.
>
> Offsets will be applied to the months following an approval. In general, the allowable expenses are the same as allowed for a group 2 deductible case. In addition, the medical expense(s) must be:
>
> - Unpaid, and an obligation still exists to pay.
> - Cannot be from a month where Medicaid eligibility existed.
> - Cannot be covered by a third party source (public or private).
> - Cannot be from a month in which a divestment penalty has been imposed.
> - Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
> - Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
> - Must be reported prior to the first Medicaid redetermination following the initial eligibility.

- DCH will terminate offsets if there is a failure to pay the medical provider with the funds. (Emphasis added).

BEM 546 states in part:

PATIENT PAY OFFSETS

Long-term care (LTC) facilities may deduct the following from a per-son's patient-pay amount:

- The cost of certain medically necessary services **not** covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers, and
- The MA co-payments for covered services.

The remainder of the patient-pay amount is then applied to the cost of care provided by the LTC facility. The Department of Community Health determines whether an offset is allowable.

Patient-pay amounts are **not** offset by local office staff.

Note: If an LTC applicant requests an offset of the patient pay to cover old medical bills see PEME in glossary and in this item. Assist the applicant by forwarding the unpaid bills to:

Medical Services Administration
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-9634
Attn: PEME

DCH will determine whether an offset is allowable.

- Offsets will be applied to the months following an approval. In general the allowable expenses are the same as allowed for a group 2 deductible case. In addition the medical expense(s):
- Must be unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third-party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.

- Cannot have been used previously as a pre-eligibility medical expense to offset a patient-pay amount.

- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.

- Must be reported prior to the first Medicaid redetermination following the initial eligibility.

Note: DCH will terminate offsets if there is a failure to pay the medical provider with the funds. [Emphasis added].

The *Bridges Policy Glossary* 7-1-2014 contains the following definitions:

INITIAL APPLICATION

The most recent application used to establish eligibility at the time any currently active assistance program was opened. (p. 34 of 70).

* * *

PRE-ELIGIBILITY MEDICAL EXPENSE

Unpaid medical expenses incurred in the three months prior to application for Medicaid. The offset is only allowed if used to pay the provider(s) for the medical expense and will be terminated if the recipient fails to pay the provider. In general the allowable expenses are the same as allowed for a group 2 deductible case. In addition, the medical expense(s) must be:

- Unpaid, and an obligation still exists to pay.

- Cannot be from a month where Medicaid eligibility existed.

- Cannot be covered by a third party source (public or private).

- Cannot be from a month in which a divestment penalty has been imposed.

- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.

- Can include cost of room and board for Medicaid long term care (LTC) facilities, remedial care and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.

- Must be reported prior to the first Medicaid redetermination following the initial eligibility.

- DCH will terminate offsets if there is a failure to pay the medical provider with the funds. [pp. 50-51 of 70, emphasis added].

The facts in this case are not in dispute. Rather, the application of the State Plan and the policy set forth in BEM 164 and BEM 546 adopted to implement the State Plan is at issue in this case. The Department's witnesses established that the Appellant's request for PEME offset for the expenses incurred from [redacted] through [redacted] was denied because the request and medical expenses were not reported prior to the first Medicaid redetermination following the Appellant's initial eligibility for Medicaid.

The Department's witnesses established that the policy set forth in BEM 164 and 546 was adopted in 2010 in response to a class action law suit that was settled in the *Miller* case. It was established that in the past there were problems with beneficiaries transitions into nursing facilities and the establishment of Medicaid eligibility and the new policy authorizing PEME offsets was designed to address the unpaid medical bills that would often result from these problem transitions. The Department intended the PEME offsets to be a one-time deduction following the beneficiary's initial eligibility determination following their transition to the nursing home.

Appellant attempts to apply the definition in the Bridges Policy Glossary that defines the term "initial application" as the most recent application used to establish eligibility at the time any currently active assistance program was opened. Appellant urges that the policy in BEM 164 and BEM 546 must be applied consistent with this definition, and if so applied, the [redacted] application would be Appellant's "initial application" and the eligibility from this application should be considered his "initial eligibility". Based on such an interpretation, Appellant asserts that his request for a PEME offset for the expenses incurred from [redacted] through [redacted] should be allowed.

The problem with the Appellant argument is that the term used in BEM 164 and BEM 546 is "initial eligibility" not "initial application". Appellant's "initial eligibility" for Medicaid was established in [redacted]. Due to a couple of breaks in Medicaid eligibility, the Appellant's first Medicaid redetermination following the Appellant's initial eligibility for Medicaid was not due unti [redacted], and the failure of the Appellant to return the redetermination paperwork in a timely manner resulted in another gap in his Medicaid eligibility. The Bridges Administrative Manual (BAM) BAM 210 p. 1 of 20, 7-1-2014, requires a complete redetermination at least every 12 months. The State Plan to allow for "reasonable and necessary medical expenses" as implemented by the policy set forth in the BEM was meant to cover only those expenses that are incurred when problems arise during a beneficiary's initial transition into a nursing facility and there is a delay in a determination of his "initial eligibility" for Medicaid. The policy cannot have

been meant to benefit a Medicaid Beneficiary every time he has a break in his Medicaid eligibility due to his failure to make a timely submission of his redetermination paperwork.

Based on the above findings of fact and conclusions of law, Appellant has failed to prove, by a preponderance of the evidence that the Department erred in denying his request for application of a PEME offset to the expenses incurred from [redacted] through [redacted]. Appellant's request for PEME offset for the expenses incurred from [redacted] through [redacted] was denied because the request and medical expenses were not reported to the Department prior to the first Medicaid redetermination following the Appellant's initial eligibility for Medicaid. As such, the Department's denial of a PEME offset to the expenses incurred from [redacted] through [redacted] must be upheld.

DECISION AND ORDER

The Department properly denied Appellant's request for a PEME offset for the expenses incurred from [redacted] through [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/db

cc: [redacted]

***** NOTICE *****
The Michigan Administrative Hearings System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearings System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant 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.