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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-007561
Issue No.: 2002
Case No.: [redacted]
Hearing Date: September 22, 2015
County: Allegan

ADMINISTRATIVE LAW JUDGE: C. Adam Purnell

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; and Mich Admin Code, R 792.11002. After due notice, telephone conference hearing was held on September 22, 2015 from Lansing, Michigan. Attorney [redacted] represented the [redacted] and Claimant. [redacted] (Business Office Manager at [redacted]) testified as a witness for Claimant. Assistant Attorney General (AAG) [redacted] represented the Department of Health and Human Services (Department). [redacted] (Long Term Care Specialist) appeared as a witness for the Department.

ISSUE

Did the Department properly deny Claimant's applications for Medical Assistance (MA) and retroactive MA benefits due to failure to timely return the required verifications?

FINDINGS OF FACT

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

1. During the relevant time period, Claimant resided at the [redacted], which is a skilled nursing and rehabilitation center.

2. On January 30, 2015, the Department received Claimant's application for Long Term Care (LTC) MA[2] or Medicaid (DHS-4574) and Retroactive Medicaid

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[1] [redacted] is not admitted to the practice of law in the State of Michigan and appeared in this matter pursuant to an Order Granting Motion for Temporary Admission (Pro Hac Vice) of Out-of-State Attorney.

[2] The application was completed and signed by Claimant's son, [redacted]. See Exhibit 1, p 10.

Application (DHS-3243) seeking reimbursement for unpaid medical bills for October, November and December, 2014. (Exhibit 1, pp 7- 12)

3. On the DHS-4574, Claimant listed the following assets: "mobile home," "stocks: [redacted], [redacted], [redacted] and an account at '[redacted] (Exhibit 1, p 8)

4. On February 5, 2015, the Department mailed to Claimant (and Claimant's son) a Verification Checklist (DHS-3503) which included the following under the comments section:

> Please submit complete statements for the three (3) previously reported mutual fund accounts [redacted], [redacted] beginning 10-1-2014 thru present. These statements must contain the bank name, owner name(s), date, account#, daily balance summary and balances. If any of these accounts have closed you will need to provide proof of closure. If any funds in these accounts have been spent to be eligible for Medicaid, please submit this proof. Also it was previously reported you lived in a mobile home. Please submit proof of ownership of this mobile home and if it has been sold, rented, etc, Thank you, Laurel. (See Exhibit 1, p 13) The deadline to provide the requested verifications was February 17, 2015. (Exhibit 1, p 13)

5. On February 17, 2015, [redacted], Business Office Manager from the [redacted], (Business Office Manager) sent an email to [redacted] requesting an extension to provide the bank statements. (Exhibit 1, p 6) [redacted] granted the extension until February 27, 2015 but indicated that the verifications must be faxed to Lansing. (Exhibit 1, p 5)

6. On February 17, 2015, the Department mailed Claimant (and Claimant's son) another Verification Checklist (DHS-3503) which was identical to the February 5, 2015 DHS-3503, except the new due date for the verifications was February 27, 2015. (Exhibit 1, pp 15-16)

7. On February 27, 2015, the Business Office Manager sent an email to [redacted] indicating that she was faxing more documents and still waiting on the 20 share one to get cashed in but that it should be in by the first of next week. The Business Office Manager then requested another extension. (Exhibit 1, p 5)

8. On March 2, 2015, [redacted] sent an email to the Business Office Manager indicating that she can do 1 (one) more extension. The due date is now March 12, 2015. (Exhibit 1, p 5)

9. On March 2, 2015, the Department local office in Allegan County mailed Claimant (and Claimant's son) a Verification Checklist, which requested the same verifications as in the previous two checklists, except this had a new due date of March 12, 2015. (Exhibit 1, pp 17-18)

10. On March 12, 2015, the Business Office Manager, in an email to the LTC Specialist, indicates that all requested documents have been provided except for proof of 1 stock ([redacted] 20 shares). The Business Office Manager indicates she has proof that Claimant still owns the stock and the broker is trying to sell them but would not indicate how much longer it would be. The Business Office Manager then notes that she does not have the money nor does she have the verification of their worth. She then asks whether the application may be approved with the most recent value of the stock as a divestment. The Business Office Manager indicates that she believes she turned in all the requested documentation, but wants to know if she missed anything to let her know as soon as possible so she can get it. (Exhibit 1, p 5)

11. The Department did not receive all requested verifications by the March 12, 2015 due date.

12. On March 17, 2015, the Department's Allegan County local office mailed Claimant's son a Benefit Notice (DHS-176) which denied Claimant's Medicaid application because the requested information was not received timely. The DHS-176 further indicated, "If this information was mailed to the Lansing location and received timely by Lansing, I will be able to reinstate this case once I receive the information. Otherwise, you will need to reapply." (Exhibit 1, pp 32-33)

13. On March 18, 2015, the LTC Specialist sent an email to the Business Office Manager and apologized for not responding sooner but she was out of the office and the computers were down with no access to email. The LTC Specialist noted that the case closed and that Claimant should reapply. (Exhibit 1, p 4)

14. On March 18, 2015, the Business Office Manager sent an email to the LTC Specialist which indicated, among other things, that the only outstanding stock is the 20 shares. (Exhibit 1, p 3)

15. The Department received a request for hearing from Claimant's attorney challenging the denial of the application on April 15, 2015. (Request for Hearing)

CONCLUSIONS OF LAW

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

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department

of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

BAM 105 (1-1-2015), page 1, provides that clients have rights and responsibilities that are specific in this item. The Department's local office is required to: (1) determine eligibility; (2) calculate the level of benefits; and (3) protect client rights. BAM 105, p 1.

Clients (and authorized representatives) have the responsibility to cooperate with the local office in determining initial and ongoing eligibility. BAM 105, p 8. Clients who are able but refuse to provide necessary information or take a required action are subject to penalties. BAM 105, p 9. Clients must take actions within their ability to obtain verifications and the Department must assist when necessary. BAM 105, p 12.

Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements. BAM 130 (10-1-2014), p 1. The Department obtains verification when: (1) required by policy[3]; (2) required as a local office option. The requirement must be applied the same for every client. Local requirements may **not** be imposed for Medicaid Assistance (MA); (3) information regarding an eligibility factor is unclear, inconsistent, incomplete or contradictory. The questionable information might be from the client or a third party. Verification is usually required at application/redetermination and for a reported change affecting eligibility or benefit level. Verification is not required when the client is clearly ineligible, or for excluded income and assets unless needed to establish the exclusion. BAM 130, p. 1. BAM 130, p 1.

The Department worker must tell the client what verification is required, how to obtain it, and the due date. BAM 130, p 3. The Department sometimes will utilize a verification checklist (VCL) or a DHS form telling clients what is needed to determine or redetermine eligibility. See Bridges Program Glossary (BPG) at page 47.

For Medicaid, the Department allows the client 10 calendar days (or other time limit specified in policy) to provide the verification requested. If the client cannot provide the verification despite a reasonable effort, extend the time limit **up to two times.** BAM 130, p 7. (Emphasis added)

At application, redetermination, ex parte review, or other change, explain to the client/authorized representative the availability of your assistance in obtaining needed information. Extension may be granted when the following exists:

- The customer/authorized representative need to make the request. An extension should not automatically be given.
- The need for the extension and the reasonable efforts taken to obtain the verifications are documented.

[3] Bridges Eligibility Manual (BEM) items and MAGI policy specify which factors and under what circumstances verification is required.

- Every effort by the department was made to assist the client in obtaining verifications. BAM 130, p 7.

The client must obtain required verification, but the local office must assist if they need and request help. BAM 130, p 3. Policy further instructs, "If neither the client nor the local office can obtain verification despite a reasonable effort, use the best available information. If no evidence is available, use your best judgment." BAM 130, p 3.

If the individual indicates the existence of a disability that impairs their ability to gather verifications and information necessary to establish eligibility for benefits, offer to assist the individual in the gathering of such information. BAM 130, p 1.

Verifications are considered to be timely if received by the date they are due. For electronically transmitted verifications (fax, email or MI Bridges document upload), the date of the transmission is the receipt date. BAM 130, p 7.

Send a case action notice when:

- The client indicates refusal to provide a verification, **or**
- The time period given has elapsed. See BAM 130, p 7.

In the instant matter, Claimant, by counsel, argues that the Department's decision to deny the application should be reversed because the Department failed to comply with federal and state law with regard to obtaining verification of financial information. In support, Claimant makes 3 (three) arguments.

First, Claimant argues that 42 U.S.C. §1396 requires all states to implement electronic asset verification systems (AVS) to verify assets for Medicaid applicants. (Appellant's Post-Hearing Summary, p 1) According to Claimant, caseworkers, if unable to obtain an applicant's financial information using the AVS database, caseworkers must request this information from other states, third parties or the federal government. (Appellant's Post-Hearing Summary, p 2) Claimant contends that federal law (20 CFR §435.948) prohibits caseworkers from requesting the Medicaid applicant provide verification as the information is available through the electronic system. (Appellant's Post-Hearing Summary, p 2)

Claimant further asserts that 20 CFR §416.1201(a)(1) prohibits a caseworker from denying a Medicaid application if the caseworker is unable to obtain the necessary verifications from the AVS or by other means. (Appellant's Post-Hearing Summary, p 2) Claimant submits that a Medicaid applicant may only be denied under these circumstances when he or she refuses to obtain verification information. (Appellant's Post-Hearing Summary, p 2) Claimant contends that the Department caseworker in this matter made no attempt to obtain Claimant's information electronically through AVS or from secondary sources.

Second, Claimant argues that his disability caused, or hampered, his ability to obtain the necessary verifications by the due date. The Department's failure to grant Claimant an additional extension is a violation of 42 U.S.C. §12101 et seq., (i.e., the Americans with Disabilities Act (ADA)). In addition, Claimant indicates that Michigan law (MCL §600.5851-tolling of the statute of limitations) allows for deadlines to be extended when a person suffers from a disability. (Appellant's Post-Hearing Summary, pp 3-4)

Finally, Claimant alleges that the Department's denial of his Medicaid application violates the U.S. Constitution and may be actionable under 42 U.S.C. §1983. (Appellant's Post-Hearing Summary, pp 4-5)

The Department, on the other hand, argues that it properly denied Claimant's application for LTC Medicaid because Claimant failed to provide requested verifications by the due date. (Respondent's Post-Hearing Brief, pp 1-2) The Department relies upon BAM 105, 130 and BAM 400. Essentially, the Department takes the position that applicable policy places the responsibility on the applicant to provide verifications necessary to determine eligibility for Medicaid.

Testimony and other evidence must be weighed and considered according to its reasonableness. *Gardiner v Courtright*, 165 Mich 54, 62; 130 NW 322 (1911); *Dep't of Community Health v Risch*, 274 Mich App 365, 372; 733 NW2d 403 (2007). The weight and credibility of this evidence is generally for the fact-finder to determine. *Dep't of Community Health*, 274 Mich App at 372; *People v Terry*, 224 Mich App 447, 452; 569 NW2d 641 (1997). Moreover, it is for the fact-finder to gauge the demeanor and veracity of the witnesses who appear before him, as best he is able. See, e.g., *Caldwell v Fox*, 394 Mich 401, 407; 231 NW2d 46 (1975); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996).

This Administrative Law Judge has carefully considered and weighed the testimony and other evidence in the record. Claimant initially argues, by implication, that the Department's verification policies violate federal law. This Administrative Law Judge disagrees and finds that the Department's verification policies do not conflict with the federal authority cited by Claimant.

Claimant's argument that 42 U.S.C. §1396 et seq., requires the Department utilize the AVS to verify Claimant's assets is unpersuasive. The AVS would not allow the Department to verify the value of Claimant's stock assets if this information was not contained in a database held by another state or the federal government. There is no evidence in this record that Claimant's stocks were available on any public database. Here, the evidence in this case shows that the only way the Department could obtain this information would be from Claimant or his representative. Between Claimant and the Department, Claimant (or the Business Office Manager) was in a better position to obtain verification of his own stock assets. In this case, Claimant has not shown how (or even if) this information is available to the Department through other means.

This Administrative Law Judge also finds that 20 CFR §435.948 does not place the burden on the Department to obtain verification information that is only available to Claimant. This would result in the Department either being unable to properly determine a person's Medicaid eligibility or providing Medicaid eligibility to person's who may not meet the eligibility criteria.

Claimant argues that federal law (20 CFR §416.1201(a)(1)) controls in this case. Even if 20 CFR §416.1201(a)(1) is applicable to the instant set of facts, it does not prohibit the Department from denying an application where the Department lacks sufficient information to determine eligibility. BAM 105, page 1 requires the Department determine eligibility. In order for the Department to do so, it must have sufficient information about Claimant's assets. Federal law does not require the Department provide Medicaid benefits to an applicant that has not shown that he or she is eligible.

In this matter, the parties do not dispute that Claimant failed to provide all the requested verifications. Specifically, the outstanding verification consisted of 20 shares of stock. (Exhibit 1, p 5) The hearing record shows that both the LTC Specialist and Business Office Manager exchanged emails where they discussed the outstanding stock account. In this exchange, it was initially believed that Claimant had 20 shares of stock with [redacted]., but that the Department required verification of the stock value.

The LTC Specialist acted properly and complied with BAM 130, page 3 when she extended the deadline to provide the verification on at least 2 occasions. BAM 130 does not require the Department to grant additional extensions into perpetuity. Here, neither the Business Office Manager nor the LTC Specialist was able to obtain verification despite a reasonable effort and the LTC Specialist used her best judgment which was to deny the application. The record shows that the Department did not have sufficient information to grant the application as there was no evidence Claimant was asset eligible for Medicaid. The Department is without authority to grant Medicaid benefits to a person who has not shown that he or she meets all of the eligibility criteria.

The contention that Claimant was prejudiced because the LTC Specialist failed to respond to the Business Office Manager's email until after the due date is also not persuasive. There is no evidence in this record that Claimant was prejudiced or that the Department would have been in a position to determine Medicaid eligibility or approve the application. The reality is that Claimant had sufficient opportunities to provide the requested verifications. The record shows that the LTC Specialist was attentive and responded to the Business Office Manager's inquiries.

The argument that Claimant's disability or incapacity prevented him from does not apply in this case. The record shows that Claimant's brother was acting as his representative and the Claimant also had assistance from the [redacted] Business Office Manager.

To the extent Claimant argues that the Department has discriminated against him due to a disability or is subject to liability under 42 U.S.C. §1983, an Administrative Law Judge lacks the authority to address such claims. Administrative Law Judges have no

authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations, or make exceptions to the department policy set out in the program manuals. It is well-settled law that an administrative adjudicator does not have authority to decide constitutional issues. *Dation v Ford Motor Co*, 314 Mich 152 (1946); *Flanigan v Reo Motors, Inc*, 300 Mich 359 (1942); *Mackin v Detroit Timkin Axle Co*, 187 Mich 8 (1915). Furthermore, established Michigan case law provides that administrative adjudication is an exercise of executive power rather than judicial power, and restricts the granting of equitable remedies. *Michigan Mutual Liability Co, v Baker*, 295 Mich 237; 294 NW 168 (1940).

The material, competent and substantial evidence on the whole record demonstrates that the Department acted properly when it denied Claimant's Medicaid application due to failure to provide requested verifications.

DECISION AND ORDER

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

C. Adam Purnell
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: 10/12/2015

Date Mailed: 10/12/2015

CAP/las

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date. A copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Hearing Decision from MAHS within 30 days of the mailing date of this Hearing Decision, or MAHS **MAY** order a rehearing or reconsideration on its own motion.

MAHS **MAY** grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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 48909-8139

cc: