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

IN THE MATTER OF:

Reg. No.: 15-010782
Issue No.: 2002
Case No.:
Hearing Date: September 22, 2015
County: Kent-District 1

ADMINISTRATIVE LAW JUDGE: C. Adam Purnell

HEARING DECISION

This matter was brought 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 following a request for a hearing filed by Claimant's Authorized Hearing Representative (AHR). After due notice, a telephone hearing was held on September 22, 2015 from Lansing, Michigan. Claimant's AHR , Benefits Specialist from represented Claimant and (Claimant's Guardian) testified as a witness. (Family Independence Manager) represented the Department of Health and Human Services (Department).

ISSUE

Did the Department properly close Claimant's Medicare Savings Program (MSP) or "Medicare Cost Share" benefits case due to failure to provide requested 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. Claimant has a developmental disability. (Exhibit 1, pp 4-7)

2. On December 30, 1997, the Trust for Irrevocable Trust Agreement ("") was executed. (Exhibit 1, pp 23-29)

3. On July 19, 2010, the Kent County Probate Court issued an Order appointing a partial guardianship for Claimant. (Exhibit 1, pp 6-7)

4. Claimant resides at ., a residential facility for the developmentally disabled.

5. Claimant was active for MA and MSP benefits.

6. Claimant's MA case was scheduled for redetermination in May, 2015.

7. On April 28, 2015, Claimant submitted an online redetermination form (DHS-1010). (Exhibit 1, pp 12-18) Claimant, on her redetermination form, reported the following:

   a) Under the "other liquid asset information" section (page 4), she listed that she had "trust and/or annuities and under "Bank Name" indicated "Special Needs Trust." (Exhibit 1, p 15)

   b) "Medicare" effective date of July 1, 2007. (Exhibit 1, p 16)

   c) Under "Changed Household Bills" section, she reported having "Rent or Lot Rent" in the amount of "$ [sic] monthly effective January 1, 2015. (Exhibit 1, p 16)

8. On May 12, 2015, the Department mailed Claimant a Verification Checklist (DHS-3503), which requested Claimant, on or before May 22, 2015, provide one of the following concerning her Medicare Cost Share case:

   a) Issuing company/agency/organization statement

   b) Copy of trust document

   c) Trust management company statement

   d) Trustee records

   e) Copy of document transferring ownership of assets to the trust

   f) Statement from knowledgeable source (Exhibit 1, p 19)

9. The Department, on May 12, 2015, received a copy of the and forwarded it to the Trust/Annuities Unit for review. (Exhibit 1, p 22)

10. On May 15, 2015, the Trust/Annuities Unit issued a Memorandum which found that the failed to meet the conditions of an Exception A, Special Needs Trust. (Exhibit 1, pp 30-31)

11. On May 15, 2015, the Department mailed Claimant a Verification Checklist (DHS-3503), which appeared to request the same documents as the previous DHS-3503 issued on May 12, 2015. However, this DHS-3503, under the comments section, requested that Claimant "send in proof of what the balance is in the trust currently. The proof should be dated within the last 30 days." The proofs are due by May 26, 2015. (Exhibit 1, p 33-34)

12. As of May 26, 2015, Claimant did not provide the Department with the current balance or amount contained in the .

13. On May 26, 2015, [redacted] (the Department caseworker), in emails to [redacted], confirmed that the Department, in the May 15, 2015 verification request, sought the amount in the [redacted]. (Exhibit 2, p 3)

14. On June 4, 2015, [redacted] sent an email to the Department caseworker which indicated that Claimant's guardian established the [redacted] 20 years ago as a Special Needs Trust. [redacted] also indicated that the guardian asked for clarification on why it was considered to be established by the consumer and how she can prove that it is not. [redacted] asks that the Department caseworker forward the matter to the trust department [Trust/Annuities Unit] for clarification. In a response email, the Department caseworker indicated that the trust had been returned to the Trust/Annuities Unit. (Exhibit 2, p 1)

15. On June 4, 2015, the Department mailed Claimant a Health Care Coverage Determination Notice (DHS-1606) which indicated that Claimant's Medicare Cost Share (MSP) is closed because the Department did not receive proof of the amount in the trust. (Exhibit 1, pp 37-39)

16. On June 15, 2015, [redacted] (Claimant's AHR) requested a hearing concerning the potential closure of Claimant's MA case and the closure of MSP benefits case. (Exhibit 1, pp 2-3)

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.

Medical Assistance (MA) is also referred to as "Medicaid." BEM 105 (10-1-2014), p 1. 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, p 1.

A person entitled to Medicare Part A, Hospital Insurance, may be eligible for a Medicare Savings Program described in BEM 165. The person may be eligible for just a Medicare Savings Program or a Medicare Savings Program in addition to regular MA benefits. BEM 105, pp 2-3.

Medicare Savings Programs are SSI-related MA categories. Qualified Medicare Beneficiaries (QMB) is also called full-coverage QMB and just QMB. Program group type is QMB. BEM 165 (1-1-2015), p 1. QMB pays: (1) Medicare premiums (QMB pays Medicare Part B premiums and Part A premiums for those few people that have them); (2) Medicare coinsurances; and (3) Medicare deductibles. BEM 165, p 2.

Clients and their authorized representatives must cooperate with the local office in determining initial and ongoing eligibility. This includes completion of necessary forms. BAM 105 (4-1-2015), 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. BAM 105, p. 12; BAM 130 and BEM 702. 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. Verification is usually required upon application or redetermination and for a reported change affecting eligibility or benefit level. BAM 130, p 1.

Verifications are considered timely if received by the date they are due. BAM 130, p 6. For the Medicaid or (MA) program, the client has 10 days to provide requested verifications (unless policy states otherwise). BAM 130, p 7. If the client cannot provide the verification despite a reasonable effort, the department worker may extend the time limit up to two times. BAM 130, p 7.

According to BAM 130, page 7, at application, redetermination, ex parte review, or other change, the Department shall 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.

- Every effort by the department was made to assist the client in obtaining verifications.

See BAM 130, p 7.

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.

Before determining eligibility, the Department will give the client a reasonable opportunity to resolve any discrepancy between his statements and information from another source. The Department will send a case action notice when the client indicates refusal to provide a verification or the time period given has elapsed. BAM 130, p 8.

The Department worker must tell the client what verification is required, how to obtain it, and the due date. The client must obtain required verification, but the local office must assist if they need and request help. BAM 130, p 3. BAM 105, page 13 also requires the local office assist clients who ask for help in completing forms or gathering verifications. The Department sometimes may 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.

If neither the client nor the local office can obtain verification despite a reasonable effort, the Department must use the best available information. If no evidence is available, the Department employee may use his or her best judgment. BAM 130, p 3.

Here, Claimant's AHR argues that the Department should not have closed Claimant's MSP case[1] because the Trust/Annuities Unit erred when it evaluated Claimant's trust document. The DHS-1606 indicated that Claimant's MSP case was closed due to failure to return requested verifications and due to ineligibility. Although somewhat unclear, Claimant's AHR appears to argue that the Department's verification checklist did not clearly request that Claimant provide the current amount of the trust and the parties were engaged in ongoing discussions concerning the verification requests both prior to and after the date of closure. The Department representative, on the other hand, contends that Claimant's MSP case was properly closed due to failure to provide requested verifications by the May 26, 2015 due date.

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).

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[1] The Department did not include an eligibility summary as an exhibit in this matter, but the representative who attended the hearing testified that Claimant was active for QMB benefits.

This Administrative Law Judge has carefully considered and weighed the testimony and other evidence in the record. To the extent Claimant's AHR intends to challenge the May 15, 2015 determination by the Trust/Annuities Unit, it should be noted that the Trust/Annuities Unit memorandum is not an official department action (i.e., notice of case action, health care coverage determination notice, etc.,) that may be appealed. BAM 600 (4-1-2015), p 1, provides, "Clients have the right to contest a department decision affecting eligibility or benefit levels whenever they believe the decision is incorrect. The department provides an administrative hearing to review the **decision** and determine its appropriateness in accordance to policy." (With emphasis added). The Trust/Annuities Memorandum in this case specifically indicates, "This is an evaluation of the trust/annuity only. This is not a determination of eligibility." (Exhibit 1, p 32) The memorandum is not a decision as defined by BAM 600, p 1. Here, the Department's determination of eligibility was set forth in the DHS-1606 which found that Claimant failed to provide requested verifications. (Exhibit 1, p 37) At the time, the Department's action was based upon Claimant's failure to provide requested verifications rather than the Trust/Annuities Unit's interpretation and evaluation of the [redacted]

Here, the Department's May 15, 2015 verification checklist (DHS-3503) clearly requests Claimant provide proof of the current amount in the [redacted]. (Exhibit 1, p 33) Although Claimant's AHR requests clarification regarding what was needed on May 22, 2015 and the Department caseworker on May 26, 2015 (the date verifications were due) again indicated that the verification checklist concerns the amount of the [redacted], Claimant's AHR does not specifically request an extension nor does she specifically request assistance in obtaining the verifications. See BAM 105, p 3 & BAM 130, p 13. Policy does not require the Department provide an extension for verifications where Claimant has not requested one.

The additional emails exchanged between Claimant's AHR and the Department caseworker largely concern questions about whether the Trust/Annuities Unit properly evaluated the [redacted]. (Exhibit 2, pp 5-10) These emails show ongoing discussions that continued both before and after the May 26, 2015 due date. Although the Department worker forwarded information to the Trust/Annuities Unit and emails concerning the trust language were exchanged, the Department representative, on June 16, 2015, indicated to Claimant's AHR that the case was closed. (Exhibit 2, p 7) At this time, Claimant's AHR never provided the Department with documentation in response to the May 22, 2015 verification request. The record also shows that Claimant's AHR never provided the Department with the balance or amount contained in the [redacted] which is precisely what the Department had requested.

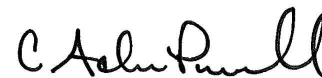
In addition, Claimant's guardian testified during the hearing that she was reluctant to provide the Department with the balance of the [redacted] because she did not obtain satisfactory responses to her questions. This can fairly be characterized as a refusal to provide requested verifications. Either way, the evidence of record does not show a reasonable effort to provide the verifications before the due date as much as it shows that Claimant's guardian had continued questions and was uncomfortable

providing the information sought by the Department. Based on the substantial, material and competent evidence on the whole record, the undersigned finds that Claimant failed to provide the Department with the verifications necessary for the Department to redetermine Claimant's MA and/or MSP eligibility.

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 closed Claimant's Medicare Savings Program/Medicare Cost Share case because Claimant failed to timely 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 Human Services

Date Signed: 9/29/2015

Date Mailed: 9/29/2015

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: