STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-013881 MSB
Case No. [redacted]

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 [redacted]. Appellant's Guardian, [redacted] and her husband [redacted] appeared and testified on her Appellant's behalf. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], Departmental Analyst, appeared as a witness for the Department.

State's Exhibits A pages 1-18 were admitted as evidence.

ISSUE

Did the Department properly reject a claim for Pre-Eligibility Medical Expenses (PEME) program for preexisting medical expenses?

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 has been on Medicaid and in Long Term Care since [redacted].

2. Appellant's first re-determination for Medicaid was in [redacted].

3. On [redacted], Appellant filed a request for Pre-Eligibility Medical Expenses (PEME) offset to cover Medical Expenses for [redacted] and [redacted].

4. On [redacted], the Department sent Appellant's Guardian Notice that he did not qualify for a Patient Pay Amount offset through the PEME program for preexisting medical expenses.

5. On [redacted], Appellant's Guardian filed a request for a hearing to contest the Department's negative action.

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 Department policy on coordination of benefits states:

> **SECTION 1 – INTRODUCTION**
>
> This chapter applies to all providers.
>
> Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.
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> ***
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> **2.6. MEDICARE**
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> **2.6.A. MEDICARE ELIGIBILITY**
>
> Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.
>
> If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.
>
> Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- 65 years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.

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Medicaid Provider Manual,
Coordination of Benefits Section,
October 1, 2013, pp 1, 6

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:

- Expenses incurred in the three months prior to application for Medicaid.
- 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.

Bridges Eligibility Manual (BEM) 164 BPB 2014-019 (10-1-2014) (Emphasis Added)

Department policy dictates that Appellant must report preexisting medical expenses prior to the first Medicaid redetermination. Appellant started receiving Medicaid in [redacted] and had his first redetermination in [redacted]. His current Guardian did not ask for reimbursement until [redacted]. The Department is not responsible for the prior guardian's failure to request PEME in [redacted]. The Department has established by the necessary competent, substantial and material evidence on the record that it acted in accordance with Department policy when it determined that Appellant was not eligible to receive PEME program benefits under the circumstances.

The Appellant's grievance centers on dissatisfaction with the department's current policy. The Appellant's request is not within the scope of authority delegated to this Administrative Law Judge pursuant to a written Delegation of Authority signed by the Michigan Department of Community Health (now Health and Human Services) Director, which states:

> Administrative law judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulation, or overrule or make exceptions to Department policy. (February 22, 2013)

Furthermore, 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 NW168 (1940).*

This Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness.

[redacted]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly rejected the claim for Pre Existing Medical Expenses.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[redacted]

Date Signed: October 13, 2015

Date Mailed: October 13, 2015

***** NOTICE *****

The Michigan Administrative Hearing 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 Hearing 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.