RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: March 15, 2016
MAHS Docket No.: 15-024287
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: C. Adam Purnell

HEARING DECISION

Following Petitioner'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, an in-person hearing was held on March 9, 2016, from Allegan, Michigan. [redacted] (Authorized Hearing Representative (AHR) from the [redacted]. Petitioner did not appear at the hearing. [redacted] (Long Term Care (LTC) Specialist) and [redacted] (Assistance Payments Specialist) represented the Department of Health and Human Services (Department).

ISSUE

Did the Department properly close Petitioner's Long Term Care (LTC) Medical Assistance (MA) 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. Petitioner is in a nursing facility. [Exhibit 1, p. 9].

2. During the relevant time period, the [redacted] ([redacted]) served as Petitioner's Authorized Representative (AR). [Exh. 1, p. 7].

3. On January 8, 2015, Petitioner's AR submitted the following:

   a. MI Choice Waiver Enrollment Notification (MSA-0814) requesting enrollment in MI Choice. [Exh. 1, p. 6].

b. Medicaid Application – Patient of Nursing Facility (DHS-4574) which listed the following:

i. Assets: Home (exempt) State Equalized Value (SEV) $[redacted] money market funds that she "plans to close . . . next week" (closed January 2, 2015); trust account with a $[redacted] balance. [Exh. 1, p. 10].

ii. Income: Social Security Benefits (RSDI) $[redacted] [Exh. 1, p. 11].

iii. Expenses: Property taxes $[redacted] for summer (September 15, 2014) and $[redacted] in winter. [Exh. 1, p. 11].

iv. Homeowners insurance: $[redacted] annual. [Exh. 1, p. 11].

4. On February 18, 2015, the Department mailed Petitioner a Health Care Coverage Determination Notice (DHS-1606) which indicated, "[y]our long term care Medicaid application has been processed and approved." The notice further indicated that Petitioner was eligible for LTC MA benefits with a $[redacted] monthly deductible for the period of January 1, 2015 through March 31, 2015. [Exh. 1, pp. 13-15].

5. On November 30, 2015, Petitioner returned a completed redetermination form (DHS-1010). The DHS-1010 indicated that Petitioner had $[redacted] in monthly income from Social Security, a checking account balance of $[redacted] and, under client comments, '[redacted] Supplemental Health Insurance Policy was cancelled this year." [Exh. 1, p. 22-25].

6. On December 1, 2015, the Department mailed Petitioner's AR a Verification Checklist (DHS-3503) which requested the following verifications regarding unearned income, assets and medical insurance:

a. Statement from [redacted] that verifies the date the medical insurance ended. [Exh. 1, p. 26].

b. Submit verification of how the allowed monthly expense ($[redacted] insurance expense) was disposed. [Exh. 1, p. 26].

c. Submit verification that compliments/explains the amount on the October 26, 2015 unearned income notice. [Exh. 1, p. 26].

d. The proofs due by December 11, 2015. [Exh. 1, p. 26].

7. On December 4, 2015, Petitioner's AR indicated that she disagreed with the Department's interpretation of policy and "will not be sending the verifications because we do not feel they are necessary." [Exh. 1, p. 31]. Later, the AR, in an email, indicated they do not want to verify the bank statements from April 2015 to current because they want to avoid setting a precedent where they allow the Department to ask for more verifications than are needed. [Exh. 1, p. 32].

8. On December 4, 2015, Petitioner's AR did forward the Department some of the requested account information. [Exh. 1, p. 32].

9. On December 4, 2015, the Department mailed Petitioner's AR the following:

   a. Verification Checklist (DHS-3503) which instructed and/or sought (1) assets (current bank statements for all savings, checking and money market accounts); (2) records of any assets sold or transferred in the last 60 months; (3) bring/send records for all assets that you have; (4) please refer to attached Quick Note. (5) the due date is December 4, 2015. [Exh. 1, p. 28].

   b. Quick Note (DHS-100) which indicated: (1) the verification checklist is due December 14, 2015; (2) please refer to email correspondence dated December 3 and 4, 2015 which seeks the following verifications: copies of monthly itemized statements of all bank accounts held by client April through October 2015; (3) copy of bill/receipt/invoice for check #[redacted] ($[redacted] and check #[redacted] ($[redacted] (4) submit a copy of the monthly itemized bank statement that verifies the value as of the app date and current statement ([redacted] account [redacted] if the account is closed, submit a copy of the statement that proves date closed and (5) balance and submit a copy of the statement that proves deposit. [Exh. 1, pp. 28-29].

10. On December 10, 2015, Petitioner's AR sent an email to the Department caseworker which attached some of the requested verifications [See Exh. 1, pp. 34-38], but indicated "we will not be providing bank statements for April 2015 - October 2015 as this recipient is consistently below the $[redacted] asset limit for Medicaid. There is no requirement for recipients to show how they spend their income monthly when they are below the asset limit. [Exh. 1, p. 33].

11. On December 15, 2015, the Department mailed Petitioner's AR a Health Care Coverage Determination Notice (DHS-1606), which closed Petitioner's LTC MA case effective January 1, 2016. The DHS-16060 indicated that the Department is unable to determine continued LTC MA eligibility because the AR failed to submit verifications needed to rule out divestment (bank statements due December 14, 2015). [Exh. 1, pp. 39-41].

12. On December 28, 2015, the Department received a request for an in-person hearing filed by Petitioner's AR to challenge the LTC MA closure for failure to return requested verifications. [Exh. 1, pp. 42-43].

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.

For all programs, both clients and the local office have certain rights and responsibilities. BAM 105 (7-1-2015), p. 1. The local office must determine eligibility, calculate the level of benefits and protect client rights. BAM 105, p. 1. The local office must review the effect on eligibility whenever the client reports a change in circumstances. BAM 105, p. 18. The local office must assist clients who ask for help in completing forms or gathering verifications. BAM 105, p. 14.

Clients, or ARs, have the responsibility to cooperate with the local office in determining initial and ongoing eligibility. BAM 105, p. 8. Clients must also cooperate with local and central office staff during quality control (QC) reviews. BAM 105, p. 8. Clients must report changes in circumstances that potentially affect eligibility or benefit amount. Changes must be reported within 10 days of receiving the first payment reflecting the change. BAM 105, p. 10. Clients who are able but refuse to provide necessary information or take a required action are subject to penalties. BAM 105, p. 9.

With regard to the MA program, [a client's] refusal to provide necessary eligibility information or to cooperate with a QC review results in ineligibility for: (1) the person about whom information is refused; and (2) that person's spouse if living in the home; and (3) that person's unmarried children under 18 living in the home. BAM 105, p. 9.

Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements. BAM 130 (7-1-2015), p. 1. The Department obtains verification under the following circumstances: (1) it is required by policy; (2) required as a local office option[1]; and (3) when information regarding an eligibility factor is unclear, inconsistent, incomplete or contradictory. BAM 130, p. 1. BAM 105, p. 12 provides that clients must take actions within their ability to obtain verifications.

Verification is usually required upon application or redetermination and for a reported change affecting eligibility or benefit level. BAM 130, p. 1. 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.

[1] The requirement must be applied the same for every client. Local requirements may not be imposed for Medical Assistance (MA).

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) (10-1-2015), p. 69.

Verifications are considered timely if received by the date they are due. BAM 130, p 6. For MA, the client has 10 days to provide requested verifications (unless policy states otherwise). BAM 130, pp. 7-8. If the client cannot provide the verification despite a reasonable effort, [the department worker may] extend the time limit up to three times. BAM 130, p. 7.

Send a negative action notice when the client indicates refusal to provide a verification, or the time period given has elapsed and the client has not made a reasonable effort to provide it. BAM 130, p. 7.

As a condition of eligibility, the client must identify all third-party resources unless he has good cause for not cooperating. Failure, without good cause, to identify a third-party resource results in disqualification. A third-party resource is a person, entity or program that is, or might be, liable to pay all or part of a group member's medical expenses. BEM 257 (5-1-2015), p. 1. Failure to cooperate without good cause results in disqualification. BEM 257, p. 4.

Policy requires the local office report to the Third Party Liability Division when a third-party resource is identified at application, redetermination or any time a resource becomes known. BEM 257, p. 5.

The Department's divestment policy is contained in BEM 405 (10-1-2015). For divestment purposes, verification is not required when the client states he and his spouse have not transferred resources unless: (1) the client's statement is unclear, inconsistent or conflicts with known facts, or (2) existing information in the case record indicates divestment may have occurred. BEM 405, p. 17.

In the instant matter, Petitioner's AR requested a hearing based on the following reasons: (1) the AR believed that the Department did not need additional verifications and that the [redacted] provided everything they felt was necessary to complete the redetermination; (2) the AR disagreed with the Department caseworker's assessment that when Petitioner cancelled her health insurance, the funds utilized by Petitioner could be considered as a divestment; (3) according to the AR, the Department cannot seek verifications of her bank accounts back from April, 2015 because even if the Department received this information, it could not be fairly considered a divestment. The Department contends that Petitioner's AR willfully refused to provide verifications, which justifies case closure according to policy.

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. Here, Petitioner's AR submits that BEM 405, p. 17 provides that the Department may not request verification of her bank account for purposes of divestment because she denied transferring any resources. The AR also submits that the exclusion of the medical expense does not constitute a transfer of a resource. The issue concerns whether the Department may request, and Petitioner must provide, verification of Petitioner's bank account to determine the presence of a divestment. The issue in this matter; however, is not whether there is a divestment. The Department did not determine that a divestment occurred in this case. Rather, Petitioner's AR, in anticipation that the Department would find a divestment, willfully refused to provide verification of Petitioner's bank account. [Exh. 1, pp. 31-32]. Thus, the salient question is whether an MA applicant or recipient may refuse to provide verifications he or she deems unnecessary.

BAM 105, p. 8, charges clients, or their ARs, with the responsibility to cooperate with the local office in determining initial and ongoing eligibility. Without cooperation from the client, the local office cannot fulfill its obligation to determine eligibility, calculate the level of benefits and protect client rights as required under BAM 105, p. 1. Here, Petitioner's AR was required to cooperate with the local office, but failed to do so.

Petitioner's AR interprets policy in such a manner as to allow a client to intentionally refuse to provide verifications the client believes are not required. Specifically, the AR asserts that BEM 405, p. 17 allows the denial of April 2015 bank statement verifications for divestment purposes when the client (or spouse) denies that he or she has transferred resources unless either the client's statement is unclear, inconsistent or conflicts with known facts, or existing information in the case record indicates divestment may have occurred. The Administrative Law Judge does not agree with this interpretation.

The method used to determine the Department's intent when it drafts policy is similar to the manner in which a court reviews legislative intent when interpreting a statute. "When interpreting statutory language, our obligation is to ascertain the legislative intent that may reasonably be inferred from the words expressed in the statute." *Koontz v Ameritech Services, Inc*, 466 Mich 304, 312; 645 NW2d 34 (2002). To this end, we "must give effect to every word, phrase, and clause in a statute, and must avoid an interpretation that would render any part of the statute surplusage or nugatory." *Id.* Statutory words must be read in context, and undefined terms are given their plain and ordinary meaning. *MidAmerican Energy Co v Dep't of Treasury*, 308 Mich App 362, 370; 863 NW2d 387 (2014). Here, BEM 405, p. 17 does not specifically provide that a client

(or an AR) may refuse to provide requested verifications where the client denies a transfer of resources. Even if somehow policy allows the denial in this instance, the Administrative Law Judge finds that the cessation of Petitioner's medical insurance expense may be a divestment. In other words, the Department may request this verification because "existing information in the case record indicates divestment may have occurred." See BEM 405, p. 17. Petitioner's AR may not determine what is or is not a divestment and then unilaterally refuse to provide verifications based on their own interpretation of policy.

The Department properly requested verification of Petitioner's April 2015 bank statements based on the fact that it was unclear whether Petitioner's lost medical insurance expense may fairly be considered a divestment. The Department caseworker credibly testified that she consulted with LTC Support/Medicaid policy staff concerning the April, 2015 bank statements and it was felt that this information may be relevant. Because Petitioner's AR failed to provide these bank statements, the issue concerning whether a divestment exists had yet to rise to the surface. Petitioner's AR acted prematurely. The proper course of action would have been to provide the requested verifications and wait for the Department to determine continued eligibility. Had the Department found that a divestment occurred, then Petitioner's AR could take action to challenge the determination. This Administrative Law Judge finds that policy does not support the refusal to provide verifications in this instance.

Policy allows the Department send a negative action notice in this instance because Petitioner's AR indicated a refusal to provide a verification and has not made a reasonable effort to provide it. BAM 130, p. 7.

The material, competent and substantial evidence on the whole record shows that the Department properly found Petitioner was no longer eligible for MA benefits because she failed to provide requested verifications.

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 Petitioner's MA case.

DECISION AND ORDER

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

IT IS SO ORDERED.

CP/las

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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

DHHS

[redacted]

Authorized Hearing Rep. [redacted]

Petitioner [redacted]