RICK SNYDER
GOVERNOR

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

MIKE ZIMMER
DIRECTOR

Date Mailed: April 11, 2016
MAHS Docket No.: 15-023846
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 28, 2016, from Pontiac, Michigan. Petitioner appeared and represented himself. Medical advocates and appeared and testified on Petitioner's behalf. The Department of Health and Human Services (Department) was represented by , Eligibility Specialist.

ISSUE

Did the Department properly process Petitioner's Medicaid (MA) case?

Did the Department properly deny Petitioner's Home Health Services (HHS) benefits for October 2015?

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 an ongoing recipient of MA benefits.

2. Petitioner receives gross monthly Retirement, Survivors and Disability Insurance (RSDI) benefits of $1156 based on a disability.

3. Petitioner is a Medicare recipient.

4. On September 16, 2015, the Department sent Petitioner a Health Care Coverage Determination Notice notifying him that he had full coverage MA for June 1, 2015 through June 30, 2015 and that he was not eligible for MA effective October 1, 2015 ongoing because he was not under age 21, pregnant, the caretaker of a minor child in the home, over age 65, blind or disabled.

5. On October 19, 2015, the Department sent Petitioner a Health Care Coverage Determination Notice notifying him that effective October 1, 2015, he was eligible for MA subject to a $623 monthly deductible (Exhibit A).

6. On December 1, 2015, the Department sent Petitioner a Health Care Coverage Determination Notice notifying him that he was eligible for MA with a $623 deductible from November 1, 2015 to November 15, 2015 and had full coverage for November 16, 2015 to November 30, 2015. The notice advised Petitioner that he was liable for $503.02 to one of his providers (Exhibit B).

7. On November 17, 2015, the Department sent Petitioner an Advance Negative Action Notice notifying him that his HHS services would be terminated effective December 3, 2015 if his MA spend down was not met and his MA case was not active by December 3, 2015 (Exhibit D).

8. On December 14, 2015, the Department received Petitioner's written request for hearing disputing the Department's actions concerning his MA and HHS cases and his Medicare Saving Program (MSP) benefits.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Adult Services Manual (ASM), 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.

In his hearing request, Petitioner disputed the Department's actions concerning his MA case, his HHS case, and his MSP benefits. At the hearing he stated that his MSP issue had been resolved and he no longer wished to proceed with a hearing concerning that

matter. Therefore, Petitioner's hearing request concerning his MSP case is dismissed. The hearing proceeded to address Petitioner's MA and HHS cases.

With respect to his MA case, Petitioner expressed concerns about the application of the deductible to activation of his MA coverage and the payment of submitted bills. Petitioner's MA coverage is subject to a $623 monthly deductible. Petitioner, who receives RSDI benefits based on a disability and is a Medicare recipient, is eligible for SSI-related MA, which is Medicaid for disabled individuals. BEM 105 (January 2015), p. 1; BEM 260 (July 2015), pp. 1-2.

In determining the SSI-related MA coverage Petitioner is eligible for, the Department must determine his MA fiscal group's net income for MA purposes. Because Petitioner is not married, his fiscal group size for SSI-related MA purposes is one. BEM 211 (January 2016), p. 8. Petitioner's gross monthly RSDI income of $1156 is reduced by a $20 disregard to arrive at net monthly income of $1136. See BEM 541 (January 2016), p. 3. Petitioner's net monthly income exceeds the $1000.83 limit applicable to a one-person fiscal group for Ad-Care eligiblity, the SSI-related MA category that provides for full-coverage MA. BEM 163 (July 2013), p. 1; RFT 242 (May 2015), p. 1. Therefore, the Department acted in accordance with Department policy when it concluded that Petitioner was ineligible for full-coverage MA.

Clients who are ineligible for full-coverage MA because of excess income are eligible for Group 2 SSI-related (G2S) MA coverage, which provides for MA coverage with a deductible. BEM 105, p. 1. The deductible is in the amount that the client's net income (less any allowable needs deductions) exceeds the applicable Group 2 MA protected income level (PIL), which is based on the client's county of residence and fiscal group size. BEM 105, p. 1; BEM 166 (July 2013), p. 2; BEM 544 (July 2013), p. 1; RFT 240 (December 2013), p. 1.

The monthly PIL for a client in Petitioner's position, with an MA fiscal group size of one living in Oakland County, is $408. RFT 200 (December 2013), pp. 1-2; RFT 240, p 1. Thus, if Petitioner's monthly net income (less allowable needs deductions) is in excess of $408, Petitioner may become eligible for MA assistance under the deductible program, with the deductible equal to the amount that his monthly net income, less allowable deductions, exceeds $408. BEM 545 (January 2015), p. 2.

In this case, the Department presented an SSI-related MA budget showing the calculation of Petitioner's deductible (Exhibit E). As discussed above, Petitioner's net income for MA purposes is $1136. Net income is reduced by health insurance premiums paid by the MA group and by remedial service allowances for individuals in adult foster care or home for the aged. BEM 544, pp. 1-3. Medicare premiums are allowable need deductions even if the cost is later reimbursed by the Buy-In program. See BEM 544, pp. 1-2. The budget shows the Department applied Petitioner's $104.90 Part B Medicare premium as an allowable needs expense. Petitioner confirmed that he had no other health insurance expenses. Because Petitioner did not reside in adult

foster care or home for the aged, he was not eligible for any other allowable need expenses. When Petitioner's net income is reduced by $104.90, his countable income is $1031, as shown on the budget. Because Petitioner's countable income of $1031 exceeded the applicable $408 PIL by $623, the Department acted in accordance with Department policy when it concluded that Petitioner was eligible for MA coverage subject to a monthly $623 deductible.

Petitioner expressed concerns about the application of his medical bills towards his deductible. Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred. BEM 545, p. 10. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the month being tested. BEM 545, p. 11. The individual must report expenses by the last day of the third month in which the group wants MA coverage. BEM 545, p. 11. Periods of MA coverage are added each time the individual meets the deductible. BEM 545, p. 11.

To determine whether a client is income eligible for MA for months with excess income, the Department must consider the expenses in the following order: (1) old bills (which excludes bills previously used to establish MA income eligibility or bills incurred on a date the person had MA coverage), (2) personal care services, (3) long-term care expenses, (4) inpatient hospitalizations, and (5) all remaining allowable medical expenses. BEM 545, pp. 3-4, 11, 19. The Department activates coverage for the client when the expenses, considered in the order listed, equal or exceed the deductible amount. BEM 545, pp. 3-4.

Income eligibility exists for the entire month when one of the following equals or exceeds the group's excess income for the month tested: old bills, personal care services, hospitalization, or long-term care. BEM 545, pp. 1, 4. If expenses for one of those categories does not equal or exceed the group's excess income for the month tested, income eligibility begins either the exact day of the month the allowable expenses exceed the excess income or the day after the day of the month the allowable expenses equal the excess income. BEM 545, p. 1.

In this case, the Department presented a copy of the documents Petitioner had submitted between June 2015 and January 2016 to establish medical expenses (Exhibit F), consisting of the following:

- Medicare Summary Notice for claims filed by [redacted] between April 15 and May 9, 2015 indicating he could be billed $283.95;
- Medicare Summary Notice for claims filed by various providers between February 3, 2015 and May 9, 2015 indicating he could be billed $767.58;
- An invoice from [redacted] (TTI) for services date October 14, 2015 totaling $416.36;
- An invoice from TTI for service dates November 2, 2015 for $43.91 and $166.54 and November 16, 2015 for $333.08;

- A December 16, 2015 print out for [redacted] showing a $19,270.72 balance for a December 7, 2015 admit date and December 8, 2015 discharge date;
- An invoice from TTI for service dates December 1, 2015 for $166.54, December 7, 2015 for $166.54 and December 21, 2015 for $333.08;
- An invoice from TTI for service dates January 25, 2015 for $46.80 and $293.28;
- A payment request from [redacted] for service date October 19, 2015 for $50.15 and an invoice from [redacted] for service dates October 19, 2015 for $5.78 marked as received by the Department on March 16, 2016.
- An invoice from TTI for service dates February 9, 2016 for $219.96 and February 29, 2016 for $495.85, including the [redacted] and [redacted] expenses of October 19, 2015 of $5.87 and $50.15, respectively.

The Department testified that the expenses listed in the Medicare Summary Notices were not considered sufficient verification of medical expenses and therefore not considered. Department policy provides that an incurred expense is verified through the bill from the medical provider, a receipt from the medical provider, or contact with the medical provider or the provider's billing service. BEM 545, p. 15. Because the Medicare Summary Notices are not from the medical provider, the Department acted in accordance with Department policy when it did not apply the expenses listed in the Notices towards the deductible.

The Department's medical expense summary (Exhibit G) shows that the Department considered all of the remaining expenses for services incurred between October 19, 2015 and January 25, 2015. According to the Department, Petitioner did not meet his deductible in October 2015 or from November 1, 2015 to November 15, 2015 but did meet his deductible for November 16, 2015 to November 30, 2015; December 2015; and January 2015.

Based on the medical bills provided, the Department properly concluded that Petitioner did not meet his deductible for October 2015. Although the expenses reported for November 2015 do not exceed $623, the Department concluded that Petitioner meet his deductible as of November 15, 2015 and he had full-MA coverage for November 16, 2015 through November 30, 2015. Based on Petitioner's December 2015 hospitalization, Petitioner met his deductible as of December 1, 2015. The information Petitioner retrieved from his online Bridges account showed that he was eligible for MA under the G2S program, that his deductible was $0, he had full MA coverage, and his MA started December 1, 2015 (Exhibit 1). While admittedly confusing, the online Bridges information is consistent with the Department's finding that Petitioner met his deductible as of December 1, 2015 and was eligible for active, full-coverage MA as of December 1, 2015 for the month of December. The additional medical expenses Petitioner submitted after his December 14, 2015 hearing request are not considered herein.

Petitioner also expressed concerns about medical expenses he had incurred between May 2015 and September 2015, alleging that he had not been advised that his MA eligibility was subject to a deductible for those months. The Department explained that Petitioner had a monthly deductible since May 2015 but, because the Department's system continued to incorrectly budget an old bill, he was found to have met his deductible for each month between May 2015 and September 2015 based on the improper processing of the old bills.

Income eligibility for MA exists when allowable medical expenses equal or exceed the excess income. BEM 545, p. 1. The Department may never reduce MA coverage already authorized on Bridges for the processing month or any past month. BEM 545, p. 12. Because Petitioner's MA coverage had been authorized for May 2015 through September 2015, it could not subsequently be reduced by changing the MA eligibility begin date to a later date. See BEM 545, p. 12. However, while Petitioner contends that the Department had failed to pay expenses he incurred between May 2015 and September 2015, there was no evidence presented that he had submitted any such expenses to the Department prior to the hearing that the Department had failed to process. While he presented additional medical expenses at the hearing, any expenses beyond those provided to the Department as of the December 14, 2015 hearing request were not properly presented for review at the hearing.

Petitioner was also concerned that the Department required that he submit proof of medical expenses within 90 days of the date the expense was incurred because he often did not receive a bill for services until well past 90 days after service was provided. Department policy provides that an individual must report expenses by the last day of the third month in which the group wants MA coverage. BEM 545, p. 11. Expenses that are not timely reported may be applied toward the deductible of the month they are reported and future months **if** they meet the conditions in BEM 545, pp. 13, 19.

In this case, Petitioner failed to present any medical expenses that he reported to the Department prior to his December 14, 2015 hearing request date that were not processed or that were not submitted by the end of the third month after the expense was incurred. Therefore, he has failed to establish that the Department acted improperly with respect to such expenses.

Petitioner's final concern was the Department's failure to pay his HHS provider and to notify him that the provider was not eligible for payment until after the provider had provided services. In order to be eligible for HHS services, a client with an MA deductible case must have met the deductible. ASM 105 (April 2015), p. 1. A client whose cost of personal care services is more than the MA deductible amount may be eligible for MA under the Medicaid personal care option, in which case the home help payment is reduced by the deductible amount and the client is responsible for paying the provider the MA deductible amount each month. ASM 105, p. 2.

In this case, the evidence showed that Petitioner did not met his deductible for October 2015. There was no evidence presented that the cost of personal care services was more than Petitioner's $623 monthly deductible. Therefore, the Department acted in accordance with Department policy when it failed to issue any payment to Petitioner's HHS provider in October 2015.

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 found Petitioner eligible for MA subject to a monthly deductible, processed the medical bills submitted prior to the hearing request, and denied payment for HHS for October 2015.

DECISION AND ORDER

Petitioner's request for hearing concerning his MSP case is **DISMISSED**.

The Department's MA and HHS decisions are **AFFIRMED**.

ACE/tlf

Alice C. Elkin
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