RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: February 24, 2017
MAHS Docket No.: 16-017732
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, and upon the Petitioner's request for a hearing.

On December 12, 2016, the Michigan Administrative Hearing System received a Request for Dismissal filed by the Respondent Michigan Department of Health and Human Services. However, the undersigned Administrative Law Judge subsequently declined to grant the Department's request given the limited record before him. The order denying the request for dismissal did note that the denial was without prejudice and that the Department could again request dismissal on the record prior to the start of the hearing if it wished.

With due notice, a telephone hearing was scheduled for January 26, 2017 at 10:00 a.m. At the time and date set for hearing, Petitioner appeared on her own behalf. [redacted]t [redacted], Petitioner's [redacted], was also present. [redacted], Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services. [redacted], Analyst, was also present for the Department.

The Department then renewed its request for dismissal on the basis that, while the Department had previously notified Petitioner that she would be referred to the Michigan Department of Treasury for a tax refund offset; Petitioner subsequently requested a Department Review with respect to that decision; the Department Review was held; and a Notice of Dismissal was sent to Petitioner, with the Notice of Dismissal stating both that contribution charges for May of 2016 and ongoing would be removed because Petitioner was pregnant and that Petitioner would not be referred to the Department of Treasury because the remaining balance that is owed is under the minimum amount for offset consideration. The Department's representative did confirm that it was still the Department's position that Petitioner has an unpaid balance, but also stated that the only methods by which the Department would take to collect that debt would be as an

offset to Petitioner's tax refund or lottery winnings, and that it is currently not attempting any such actions.

On January 27, 2017, the undersigned Administrative Law Judge issued an Order Denying the Department's Renewed Motion for Dismissal. Specifically, the renewed motion was denied because, contrary to what the Department claimed, the Department Review and subsequent Notice of Dismissal did not address the current issue in dispute. While the Department removed the contribution charges for May of 2016-ongoing and it reversed its decision to refer Petitioner to the Department of Treasury for a tax refund offset, it only reversed its decision because the remaining balance was under the minimum amount for offset consideration and it still found that there was a balance owed of [redacted]. Petitioner was disputing that alleged liability to the State of Michigan and the Department had failed to show that the undersigned Administrative Law Judge lacked jurisdiction.

After due notice, a telephone hearing was held on February 17, 2017. Petitioner appeared and testified on her own behalf. [redacted], Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services. [redacted], Analyst, testified as a witness for the Department.

During that hearing, the Department's representative stated that it was no longer contesting the undersigned Administrative Law Judge's jurisdiction in this matter. The undersigned Administrative Law Judge also noted that 42 CFR 431.220 states that the Department must grant a beneficiary an opportunity for a hearing with respect to a determination of the amount of premiums and cost sharing charges required by law.

ISSUE

Did the Department properly determine that Petitioner owed $[redacted] as part of her cost-sharing obligations?

FINDINGS OF FACT

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

1. In June of 2015, Petitioner enrolled in the Healthy Michigan Plan (HMP). (Testimony of Department's Analyst).

2. For the first six months she was enrolled in the HMP, Petitioner was not billed for any contributions or co-pays. (Testimony of Department's Analyst).

3. For example, Petitioner's MI Health Account Statement for September 8, 2015 indicated that her balance was [redacted]. (Exhibit A, pages 16-22).

4. That statement was sent to an address was in [redacted] Michigan. (Exhibit A, page 16).

5. In December of 2015, the Department began requiring contributions from Petitioner. (Testimony of Department's Analyst).

6. The amount of the required contributions were based on Petitioner's reported income, with Petitioner also receiving a reduction in her contribution amount due to a healthy behavior reward through her health plan. (Exhibit A, page 24; Testimony of Department's Analyst).

7. For the months of December of 2015, January of 2016, and February of 2016, Petitioner's contribution was set at $[redacted] per month. (Testimony of Department's Analyst).

8. Accordingly, Petitioner's MI Health Account Statement for December 14, 2015 indicated that her balance was [redacted] and she was sent three payment coupons for [redacted] with due dates of January 15, 2016, February 15, 2016 and March 15, 2016 identified on the payment coupons. (Exhibit A, pages 23-29).

9. The December 14, 2015 statement was sent to an address in Lansing, Michigan. (Exhibit A, page 23).

10. Petitioner's MI Health Account Statement for March 17, 2016 indicated that her balance for the next three months was [redacted]. (Exhibit A, pages 30-36).

11. It also indicated that Petitioner may still owe [redacted] from her last statement as one or more payments had not been received. (Exhibit A, page 31).

12. Based on her reported income and healthy behavior reward, Petitioner's contributions were set at [redacted] per month for March of 2016, April of 2016, and May of 2016. (Testimony of Department's Analyst).

13. In addition to the [redacted] in contributions for March of 2016 to May of 2016, the balance also included [redacted] in co-pays, a [redacted] each month. (Exhibit A, pages 31, 33; Testimony of Department's Analyst).

14. Attached to the March 17, 2016 statement were three payment coupons for [redacted] each, with identified due dates of April 15, 2016, May 15, 2016 and June 15, 2016. (Exhibit A, page 36).

15. The March 17, 2016 statement was sent to an address in [redacted], Michigan. (Exhibit A, page 30).

16. Overall, for the time period of December of 2015 through May of 2016, Petitioner owed [redacted] per month in contributions for December of 2015, January of 2016, and February of 2016; [redacted] per month in contributions for March of 2016, April of 2016, and May of 2016; and [redacted] per month in co-pays for March of 2016, April of 2016, and May of 2016. (Exhibit A, pages 24, 31; Testimony of Department's Analyst).

17. On April 11, 2016, Petitioner made a payment of [redacted] (Exhibit A, pages 5, 44).

18. On July 27, 2016, the Department sent Petitioner notice that she still owed [redacted] and that her case would be sent to the Department of Treasury for a tax refund offset if she did not pay. (Exhibit A, pages 16-17).

19. The notice also advised Petitioner that she could request a Department Review if she was disputing that action. (Exhibit A, page 17).

20. On August 3, 2016, Petitioner requested a Department Review. (Exhibit A, page 13).

21. The Department Review was held on September 19, 2016, and, on September 29, 2016, Appeals Review Officer [redacted] issued a Notice of Dismissal. (Exhibit A, pages 13, 45).

22. In that Notice of Dismissal, she wrote:

> In response to the Petitioner's appeal of a proposed collection of Healthy Michigan Plan (HMP) payments, a Department Review was conducted on September 19, 2016.
>
> Upon further review, the department noted that in May of 2016 the Petitioner reported she was pregnant which exempts her from any Contributions, as of that month. As such, contribution charges for May 2016-ongoing will be removed. The balance owed will be under the minimum amount for offset consideration. Therefore, the Petitioner will not be referred to the Department of Treasury for a 2017 tax refund offset. No further action will be taken in this matter.
>
> The above case is hereby DISMISSED.
>
> *Exhibit A, page 45*

23. With the charges from May 2016-ongoing removed, the Department determined that Petitioner still owed [redacted] in contribution charges. (Testimony of Department's Analyst).

24. On November 9, 2016, Petitioner was sent a MI Health Account Statement indicating that she still owed [redacted] from earlier statements. (Exhibit A, page 5).

25. On December 2, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the alleged balance owed. (Exhibit A, page 5).

CONCLUSIONS OF LAW

As discussed above, Petitioner is enrolled in the Healthy Michigan Plan (HMP). With respect to the HMP, the Medicaid Provider Manual (MPM) and Bridges Eligibility Manual (BEM) 137 state in part:

> The Healthy Michigan Plan provides health care coverage for a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.
>
> *MPM, January 1, 2017 version*
> *Healthy Michigan Plan Chapter, page 1*

Targeted Population

The Healthy Michigan Plan (HMP) provides health care coverage for individuals who:

- Are 19-64 years of age.
- Do not qualify for or are not enrolled in Medicare.
- Do not qualify for or are not enrolled in other Medicaid programs.
- Are not pregnant at the time of application.
- Meet Michigan residency requirements.

- Meet Medicaid citizenship requirements.

- Have income at or below 133% Federal Poverty Level (FPL).Cost Sharing.

The Healthy Michigan Plan has beneficiary cost sharing obligations. Cost sharing includes copays and contributions based on income, when applicable.

Copayments for services may apply to HMP beneficiaries. Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the Fee-for-Service system.

Copays are collected at the point of service, with the exception of chronic conditions and preventive services.

Healthy Michigan Plan beneficiaries, who are exempt from cost sharing requirements by law, are exempt from Healthy Michigan Plan cost-sharing obligations. Similarly, services that are exempt from any cost-sharing by law, such as preventive and family planning services are also exempt for Healthy Michigan Plan beneficiaries.

MI HEALTH ACCOUNTS

Healthy Michigan Plan managed care members are required to satisfy cost-sharing contributions through a MI Health Account. Cost sharing requirements, which include copays and additional contributions based on a beneficiary's income level, will be monitored through the MI Health Account by the health plan.

These requirements begin after the beneficiary has been enrolled in a health plan for six months.

Beneficiaries enrolled in a health plan will have the opportunity for reductions and/or elimination of cost sharing responsibilities to promote access to care if certain healthy behaviors are attained. If the amount contributed by the beneficiary is less than the amount due for a service received, the provider will still be paid in full for the services provided.

Similarly, with respect to cost sharing through the HMP, the MPM also provides:

> **SECTION 3 – COST SHARING INFORMATION**
>
> The Healthy Michigan Plan has beneficiary cost-sharing obligations. Cost-sharing includes both copays and contributions based on income, when applicable.
>
> Copayments for services may apply to Healthy Michigan Plan beneficiaries. Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the Fee-for-Service system where copays are collected at the point of service (with the exception of chronic conditions and preventive services, as described below). Healthy Michigan Plan beneficiaries who are exempt from cost-sharing requirements by law (e.g., individuals receiving hospice care, pregnant women receiving pregnancy-related services) are exempt from Healthy Michigan Plan cost-sharing obligations. Similarly, services that are exempt from any cost-sharing by law (e.g., preventive and family planning services) are also exempt for Healthy Michigan Plan beneficiaries. For general information on copayment requirements and exemptions, providers should refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.
>
> **3.1 MANAGED CARE MEMBERS – MI HEALTH ACCOUNTS**
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> Healthy Michigan Plan managed care members are required to satisfy cost-sharing contributions through a MI Health Account. Cost sharing requirements, which include copays and additional contributions based on a beneficiary's income level, will be monitored through the MI Health Account by the health plan. These requirements begin after the beneficiary has been enrolled in a health plan for six months. Beneficiaries enrolled in a health plan will have the opportunity for reductions and/or elimination of cost sharing responsibilities to promote access to care if certain healthy behaviors are attained. If the amount contributed by the

beneficiary is less than the amount due for a service received, the provider will still be paid in full for the services provided.

3.2 FEE-FOR-SERVICE BENEFICIARIES

For Healthy Michigan Plan beneficiaries who are exempt from enrollment in managed care plans or who have yet to enroll in a managed care plan, copayments for services may apply. FFS beneficiaries will not be assigned a MI Health Account.

Copayments may be required and due at the point of service for office visits, pharmacy, inpatient hospital stays, outpatient hospital visits, and non-emergency visits to the Emergency Department for beneficiaries age 21 years and older.

The MDHHS Beneficiary Copayment Table, available on the MDHHS website, provides detailed information regarding the specific services to which the copays are applied. (Refer to the Directory Appendix for website information.)

3.3 COPAY EXCEPTIONS FOR SERVICES RELATED TO CHRONIC CONDITIONS

The Healthy Michigan Plan seeks to promote greater access to services that prevent the progression of, and complications related to, chronic diseases. A specified list of chronic conditions and related drug classes has been identified for the Healthy Michigan Plan. This applies to all Healthy Michigan Plan beneficiaries whether they are in a health plan or Fee-for-Service. When services that are generally subject to copays are related to a specified chronic condition, the service will be exempt from copays.

Specifically, if the beneficiary’s visit is related to one of the program-specified chronic conditions and any diagnosis on the claim header (for institutional invoices) or any diagnosis on the claim line (for professional/dental invoices) reflects this chronic condition, there is no copay for the service. Providers are expected to submit claims in compliance with the International Classification of Diseases (ICD) coding guidelines and conventions.

> The list of chronic condition diagnosis codes and associated drug class and treatment categories subject to the copay exemption is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)
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> **3.4 COPAY EXCEPTIONS RELATED TO PREVENTIVE SERVICES**
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> For all Healthy Michigan Plan beneficiaries, both Fee-for-Service and those enrolled in a health plan, there is no copay for preventive services. MDHHS considers preventive services to include those cited in the Preventive Services subsection.
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> *MPM, January 1, 2017 version*
> *Healthy Michigan Plan Chapter, pages 6-7*

Moreover, regarding the calculation of the required co-pays and contributions, MCL 400.105d states in part:

> (b) Ensure that contracted health plans track all enrollee co-pays incurred for the first 6 months that an individual is enrolled in the program described in subdivision (a) and calculate the average monthly co-pay experience for the enrollee. The average co-pay amount shall be adjusted at least annually to reflect changes in the enrollee's co-pay experience. The department of community health shall ensure that each enrollee receives quarterly statements for his or her account that include expenditures from the account, account balance, and the cost-sharing amount due for the following 3 months. The enrollee shall be required to remit each month the average co-pay amount calculated by the contracted health plan into the enrollee's account. The department of community health shall pursue a range of consequences for enrollees who consistently fail to meet their cost-sharing requirements, including, but not limited to, using the MIChild program as a template and closer oversight by health plans in access to providers. The department of community health shall report its plan of action for enrollees who consistently fail to meet their cost-sharing requirements to the legislature by June 1, 2014.

* * *

> (e) Require enrollees described in subdivision (a) with annual incomes between 100% and 133% of the federal poverty guidelines to contribute not more than 5% of income annually for cost-sharing requirements. Cost-sharing includes co-pays and required contributions made into the accounts authorized under subdivision (a). Contributions required in this subdivision do not apply for the first 6 months an individual described in subdivision (a) is enrolled. Required contributions to an account used to pay for incurred health expenses shall be 2% of income annually. Notwithstanding this minimum, required contributions may be reduced by the contracting health plan. The reductions may occur only if healthy behaviors are being addressed as attested to by the contracted health plan based on uniform standards developed by the department of community health in consultation with the contracted health plans. The uniform standards shall include healthy behaviors that must include, but are not limited to, completing a department of community health approved annual health risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and immunization status. Co-pays can be reduced if healthy behaviors are met, but not until annual accumulated co-pays reach 2% of income except co-pays for specific services may be waived by the contracted health plan if the desired outcome is to promote greater access to services that prevent the progression of and complications related to chronic diseases. If the enrollee described in subdivision (a) becomes ineligible for medical assistance under the program described in this section, the remaining balance in the account described in subdivision (a) shall be returned to that enrollee in the form of a voucher for the sole purpose of purchasing and paying for private insurance.

Here, while it is not taking any further collection actions at this time, the Department has determined that Petitioner has an outstanding balance of [redacted] from her cost-sharing obligations.

In support of that determination, the Department's Analyst described the history of Petitioner's case and how the balance of [redacted] came to be. In particular, he testified how Petitioner was required to pay co-pays and contributions once she was enrolled in a health plan for six months and that, based on her income, her healthy behavior reward and her average monthly co-pay experience, she was billed for [redacted] per month in contributions for December of 2015, January of 2016, and February of 2016; [redacted] per month in contributions for March of 2016, April of 2016, and May of 2016; and [redacted] per

month in co-pays for March of 2016, April of 2016, and May of 2016. The Department's Analyst further testified that, while that total bill came out to [redacted] only [redacted] is currently owed as Petitioner made a one-time payment of $[redacted] and her contribution and co-pay for May of 2016 were later exempted due to her pregnancy.

In response, Petitioner testified that she never received any notice that she would be required to pay any costs until April of 2016, at which point the Department was already indicating that payments were overdue and that she had a debt. According to Petitioner, it is unfair to bill her when she received no notice. Petitioner also testified, in response to questions from the Department's representative, that she did not recall where she was living during December of 2016 when the MI Health Account Statement for December 14, 2015 was purportedly sent to her. Petitioner further testified that she went off work at the end of April and remained off work for three months, but that there were no changes prior in her reported income.

Given the above record, the undersigned Administrative Law Judge finds that the Department's decision was proper and must be affirmed. The Department's Analyst credibly testified as to how the required contributions and co-pays were calculated in this case pursuant to the policies and statute quoted above and Petitioner did not dispute any of that testimony. Instead, Petitioner only testified that she should not be billed because she never received any notice and that it would therefore be unfair. However, the undersigned Administrative Law Judge does not find her credible to the extent she claims that the Department never sent any notice prior to April of 2016, especially given her frequently shifting addresses and her inability to recall where she was living in December of 2015. Moreover, while Petitioner may claim that billing her is unfair, the above policies and statute are clear and the undersigned Administrative Law Judge lacks the authority to decide cases as a matter of equity, overrule statutes, or overrule or make exceptions to the Department's policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly determined that Petitioner [redacted] as part of her cost-sharing obligations.

IT IS, THEREFORE, ORDERED that:

The Department's decisions are **AFFIRMED**.

Steven K

SK/tm

Steven Kibit
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 30763
Lansing, Michigan 48909-8139

DHHS Department Rep.

[redacted]

[redacted]

[redacted]

[redacted]