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: April 18, 2017
MAHS Docket No.: 16-018891
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE:** Colleen Lack

## 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, a telephone hearing was held on [redacted], from Lansing, Michigan. [redacted], Petitioner, appeared on his own behalf. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payments Supervisor (AP Supervisor).

During the hearing proceeding, the Department's Hearing Summary Packet was admitted as Exhibit A, pp. 1-97.

## ISSUE

Did the Department properly determine Petitioner's eligibility for Medical Assistance (MA)?

## FINDINGS OF FACT

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

1. On [redacted], Petitioner applied for MA online for himself as well as his [redacted]-year-old daughter due to the change in household members. Petitioner did not report any income on this application. (Exhibit A, pp. 3-26 and 52)

2. Petitioner had been receiving full coverage Medicaid under his wife's Department case number. Accordingly, when the Department's computer system automatically certified Petitioner's [redacted], application, the full coverage Medicaid

eligibility determination began the next month, [redacted]. (Exhibit A, pp. 1 and 85-86; AP Supervisor Testimony)

3. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner, in part, stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, pp. 27-30)

4. Petitioner has income from Social Security Administration (SSA) issued Retirement, Survivors, and Disability Insurance (RSDI) benefits of $[redacted]. (Exhibit A, p. 1; AP Supervisor Testimony)

5. On [redacted], the assigned caseworker reviewed Petitioner's MA application and updated the income, which caused Petitioner's eligibility to change to having a deductible, or spend down, effective [redacted]. (Exhibit A, p. 1; AP Supervisor Testimony)

6. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner, in part, stating he was eligible for full coverage Medicaid effective [redacted]; and would have a monthly deductible of $[redacted] effective [redacted], and ongoing. A Deductible Report form was included. (Exhibit A, pp. 31-38)

7. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner, stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, pp. 39-41)

8. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, pp. 42-44)

9. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, p. 53)

10. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, pp. 45-47, and 54)

11. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, p. 55)

12. On [redacted], a Health Care Coverage Determination Notice was issued to Petitioner stating his Medicaid closed as he requested in a voicemail received on [redacted]. The effective date was [redacted]. (Exhibit A, pp. 48-51)

13. A printout of Petitioner's MA eligibility history shows full coverage Medicaid under his own case number from [redacted], not eligible and no coverage for [redacted], and full coverage Medicaid for [redacted], through [redacted]. (Exhibit A, pp. 85-88)

14. On [redacted], Petitioner filed a hearing request contesting the Medicaid eligibility determination and unpaid medical bills[1]. Copies of medical bills were included. (Exhibit A, pp. 52-86)

## 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.

The Medicaid program comprise several sub-programs or categories. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. Medicaid eligibility for children under 19, parents or caretakers of children, pregnant or recently pregnant women, former foster children, MOMS, MIChild and Healthy Michigan Plan is based on Modified Adjusted Gross Income (MAGI) methodology. BEM 105, (July 1, 2016), p. 1; BEM 105, (October 1, 2016), p. 1.

The State of Michigan has set guidelines for income, which determine if an MA group is eligible. In general, the terms Group 1 and Group 2 relate to financial eligibility factors. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. The income limit, which varies by category, is for nonmedical needs such as food and shelter. Medical expenses are not used when determining eligibility for MAGI-related and SSI-related Group 1 categories. For Group 2, eligibility is possible even when net income exceeds the income limit. This is because incurred medical expenses are used when determining eligibility for Group 2 categories. Group 2 categories are considered a limited benefit because a deductible is possible. BEM 105, (July 1, 2016), p. 1; BEM 105, (October 1, 2016), p. 1.

[1] The contested issues related to billing for Medicaid covered services were held under MAHS Docket No.: 16-018185.

For Group 2, income eligibility exists for all or part of the month tested when the medical group's allowable medical expenses equal or exceed the fiscal group's excess income. BEM 545, (January 1, 2016), pp. 1-3. The protected income level is a set allowance for non-medical need items such as shelter, food and incidental expenses. Reference Tables Manual (RFT) 240 lists the Group 2 MA protected income levels based on shelter area and fiscal group size. RFT 200 lists the counties in each shelter area. BEM 544 (July 1, 2016), p. 1. BEM 211, (January 1, 2016), pp. 1-9 addresses MA group composition.

For RSDI, the Department counts the gross benefit amount as unearned income. BEM 503, (July 1, 2016), pp. 28-29.

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. Each calendar month is a separate deductible period. The fiscal group's monthly excess income is called a deductible amount. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month tested. BEM 545, (July 1, 2016), pp. 10-11; BEM 545, (October 1, 2016), pp. 10-11.

In this case, on [redacted], Petitioner applied for MA online for himself as well as his [redacted]-year-old daughter due to the change in household members. Petitioner did not report any income on this application. (Exhibit A, pp. 3-26 and 52)

The AP Supervisor explained that Petitioner had been receiving full coverage Medicaid under his wife's Department case number. Therefore, when the Department's computer system automatically certified Petitioner's [redacted], application, the full coverage Medicaid eligibility determination began the next month, [redacted]. (Exhibit A, pp. 1 and 85-86; AP Supervisor Testimony) Accordingly, on [redacted], a Health Care Coverage Determination Notice was issued to Petitioner, in part, stating he was eligible for full coverage Medicaid effective [redacted], and ongoing. (Exhibit A, pp. 27-30)

However, Petitioner has income from SSA issued RSDI benefits of $[redacted]. (Exhibit A, p. 1; AP Supervisor Testimony) On [redacted], the assigned caseworker reviewed Petitioner's MA application and updated the income, which caused Petitioner's eligibility to change to having a deductible, or spend down, effective [redacted]. (Exhibit A, p. 1; AP Supervisor Testimony) Accordingly, on [redacted], a Health Care Coverage Determination Notice was issued to Petitioner, in part, stating he was eligible for full coverage Medicaid effective [redacted]; and would have a monthly deductible of $[redacted] effective [redacted], and ongoing. A Deductible Report form was included. (Exhibit A, pp. 31-38)

The AP Supervisor explained that the subsequent Health Care Coverage Determination Notices issued to Petitioner between [redacted], and [redacted], (which state he was eligible for full coverage Medicaid effective [redacted],

[redacted], [redacted], and [redacted]) appear to have been the result of a mass update. (Exhibit A, pp. 39-47 and 53-55; AP Supervisor Testimony) It appears those notices were generated in error, as there was no evidence that Petitioner's income had changed such that he would no longer have a monthly deductible for his MA eligibility starting [redacted].

The AP Supervisor explained that when the unpaid bills submitted by Petitioner with the [redacted], hearing request were applied to the monthly deductibles, the Department determined that Petitioner was eligible for the full months of [redacted], [redacted], and [redacted]. A printout of Petitioner's MA eligibility history shows full coverage Medicaid under his own case number from [redacted], not eligible and no coverage for [redacted], and full coverage Medicaid for [redacted], through [redacted]. When asked about the timeframe for applying bills to the monthly deductible, the AP Supervisor stated that under the BEM policies, there is a three-month limit. (Exhibit A, pp. 85-88; AP Supervisor Testimony)

Petitioner explained that he had been enrolled in Meridian Health Plan (MHP) when he had the full coverage Medicaid and that MHP had pre-authorized medical services. Accordingly, Petitioner proceeded with the medical services. MHP even initially paid the claims for the medical services. Then, when MHP later learned that Petitioner was found to have an unmet deductible and was unenrolled from MHP for those months, MHP took the money back from the medical providers. Subsequently, when MHP was informed that Petitioner was again found to be eligible for full coverage MA for all months but [redacted], and that he was retrospectively re-enrolled in MHP for those months, MHP repaid the medical providers for the services from those months. Accordingly, the only month there is still any issue with is [redacted]. (Petitioner Testimony) During the hearing, the AP Supervisor reviewed Petitioner's case in the Department's computer system which confirmed the MA eligibility and MHP enrollment. (AP Supervisor Testimony)

It appears that in processing the bills submitted on [redacted], the Department considered the policy provision in the version of BEM 545 that went into effect [redacted], indicating that old bills can only be applied to the monthly deductible for the past three months, the current month, or a future month. From an example set forth in the policy, for a medical expense incurred in [redacted], and reported in [redacted], the expense can be used as an old bill for [redacted], [redacted], [redacted], [redacted], or future months. BEM 545, (January 1, 2017), pp. 11-12. Further, that version of BEM 545 also requires a medical expense to be reported no later than the last day of the third month after the expense in order for it to be applied toward the deductible for the month of the date of service. From an example set forth in the policy, for a medical expense incurred in [redacted], it could be reported through [redacted], to be used toward the [redacted] deductible. BEM 545, (January 1, 2017), pp. 11-12. Accordingly, it would follow that for Petitioner's medical expenses incurred in [redacted], Petitioner would have had through [redacted], to report the expenses. Petitioner submitted documentation of

medical expenses, some of which were incurred in [redacted], on [redacted]. (Exhibit A, pp. 69-84)

However, it appears that the Department may have inadvertently omitted the portions of the BEM 545 policy setting forth what months old bills can be applied to as well as the three-month limitation for reporting medical expenses in the versions of the policy that were in effect when the initial MA eligibility determinations were made and when the documentation of medical expenses was submitted. See BEM 545, (January 1, 2016) pp. 1-31 and BEM 545 (October 1, 2016) pp. 1-31. Therefore, when Petitioner's medical expenses were submitted on [redacted], there was no provision in the BEM 545 policy requiring that an expense be reported no later than the last day of the third month after the expense, or that an old bill could only be applied to the monthly deductible for the past three months, the current month, or a future month.

Overall, the Department failed to satisfy its burden of showing that it acted in accordance with Department policy when it determined Petitioner's Medicaid eligibility. While the Department properly updated the case to include the RSDI income that was not reported on Petitioner's [redacted], MA application, no copy of the MA budget was submitted by the Department to show how the deductible amount of $[redacted] was calculated. The burden of producing evidence (i.e., going forward with evidence) involves a party's duty to introduce enough evidence to allow the trier of fact to render a reasonable and informed decision. Thus, the Department must provide sufficient evidence to enable the Administrative Law Judge to ascertain whether the Department followed policy in a particular circumstance. In this case, the Department has not provided sufficient evidence to review the deductible determination itself. Further, the Department indicated that the medical expenses reported on [redacted], which included expenses incurred in [redacted], have not been considered toward the [redacted], deductible. While some of the copies are difficult to read, it appears there were medical expenses that exceeded the calculated deductible amount for dates of service in [redacted]. (Exhibit A, pp. 69-84) At the time of the initial MA eligibility determinations and when the Department received the documentation of Petitioner's medial expense on [redacted], it appears that the versions of the BEM 545 policy in effect did not contain either of the three month limitations regarding reporting medical expenses or for using old bills toward past deductible months.

## DECISION AND ORDER

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 failed to satisfy its burden of showing that it acted in accordance with Department policy when it determined Petitioner's eligibility for MA.

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

THE DEPARTMENT IS ORDERED TO BEGIN DOING THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS

HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. Re-determine Petitioner's eligibility for MA retroactive to [redacted] in accordance with Department policy.

CL/bb

**Colleen Lack**
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**

**Petitioner**