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: May 9, 2017
MAHS Docket No.: 17-002998
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 April 27, 2017, from the [redacted] located in Flint, Michigan. Petitioner appeared and represented herself. [redacted] (Petitioner's nephew) testified as a witness for Petitioner. [redacted] Eligibility Specialist/Hearing Facilitator, appeared on behalf of the Department of Health and Human Services (Department).

The Department offered the following exhibits which were marked and admitted into evidence: [**Department's Exhibit 1**: Hearing Summary, Pre-Hearing Conference Letter, Request for Hearing, Assistance Application, Health Care Coverage Supplemental Questionnaire, Verification Checklist, SOLQ, City of [redacted] 2015 Winter Tax Bill, Account Statement from [redacted], City of [redacted] 2016 Property Tax Bill, City of [redacted] 2015 Property Tax Bill, Warranty Deed, Bridges MA Assets, Health Care Coverage Determination Notice, Verification Checklist, and Request for Hearing.].

Petitioner did not offer any exhibits into evidence.

The record closed at the conclusion of the hearing.

ISSUE

Did the Department properly determine Petitioner's eligibility for Medical Assistance (MA) and Medicare Savings Program (MSP) benefits?

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 November 19, 2016, Petitioner submitted an electronic application for health care coverage. [Department's Exhibit 1, pp. 5-12].

2. On or about November 21, 2016, the Department mailed Petitioner a Health Care Coverage Supplemental Questionnaire (DHS-1004) form, which requested additional information in order to find the most beneficial coverage for Petitioner. The DHS-1004 form indicated that Petitioner was required to complete, sign and return the document to the Department. [Dept. Exh. 1, pp. 13-16].

3. Petitioner fully completed, signed and returned the DHS-1004 form as required. The Department received the DHS-1004 form on November 28, 2016. [Dept. Exh. 1, pp. 13-16].

4. On November 28, 2016, the Department manually sent Petitioner a Verification Checklist (DHS-3503), which requested verifications of Petitioner's mortgages, land contracts, assets and the value of each home Petitioner holds in her name ([redacted] and [redacted]). The proofs were due on or before December 8, 2016. [Dept. Exh. 1, pp. 16-17].

5. On November 2, 2016, Petitioner sent the Department a Warranty Deed that indicated she owned real property located at [redacted]. [Dept. Exh. 1, p. 25].

6. On December 8, 2016, Petitioner sent the Department a 2015 Property Tax Bill (City of [redacted] for her property located at [redacted]. [Dept. Exh. 1, p. 26].

7. On December 9, 2016, Petitioner provided the Department with the following: (1) a copy of a City of [redacted] 2016 Winter Property Tax Bill which indicated that the SEV was $[redacted] (2) a financial statement from [redacted]., which indicated that Petitioner owned real property that had a $[redacted] pay off balance (the document did not identify the specific parcel of property), and a copy of a Warranty Deed, which indicated that she owned real property located at [redacted]. [Dept. Exh. 1, pp. 22, 26].

8. The Department determined that Petitioner had total countable assets in the amount of $[redacted] and that she exceeded the asset limit. [Dept. Exh. 1, pp. 27].

9. On December 22, 2016, the Department mailed Petitioner a Health Care Coverage Determination Notice (DHS-1606), which determined that Petitioner was not

eligible for health care coverage (MA and MSP), effective November 1, 2016, because she did not pass the asset test. [Dept. Exh. 1, pp. 28-31].

10. On February 27, 2017, the Department received Petitioner's request for an in-person hearing to dispute the decision to find her ineligible for MA and MCS. [Request for Hearing].

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.

Medicare is a federal health insurance program administered by the Social Security Administration (SSA). Medicare has three parts: Part A, hospital insurance (HI), and Part B, supplementary medical insurance (SMI), Part D, prescription drug coverage. A person receiving Medicare may have to pay a monthly premium for his Medicare. A person is also responsible for some of the cost of Medicare-covered services. These costs are called coinsurances and deductibles. BAM 810 (10-1-2016), p. 1.

Medicaid coverage includes Medicare cost-sharing benefits. This means Medicaid pays Medicare Part B premiums or Part A and B premiums, coinsurances and deductibles for certain Medicaid recipients. A person who can receive Medicare Part A free of charge is encouraged to apply for it. BAM 810, p. 1. [Emphasis in original].

Medicare Savings Programs are SSI-related MA categories.[1] BEM 165 (10-1-2016), p. 1. The three MSP categories are: (1) Qualified Medicare Beneficiaries (QMB); (2) Specified Low-Income Medicare Beneficiaries (SLMB); and (3) Additional Low-Income Medicare Beneficiaries (ALMB). QMB pays for Medicare premiums (Medicare Part A and Medicare Part B), Medicare coinsurances and Medicare deductibles. SLMB pays Medicare Part B premiums. ALMB pays Medicare Part B premiums provided funding is available. BEM 165, pp. 1-2.

[1] The Department sometimes refers to this as "Medicare Cost Share."

An ex parte review is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220. BEM 165, p. 8.

In the instant matter, Petitioner requested a hearing because the Department determined that she was ineligible for MA and MSP due to exceeding the asset limit. Petitioner contends that the Department incorrectly determined the value of her assets as she has no equity in the home as it is subject to a $[redacted] mortgage on the property and the property is "under water."

The Department representative who attended the hearing conceded that the Department caseworker who processed Petitioner's November 19, 2016, application failed to process it correctly. The Department representative indicated that the caseworker was unable to connect the SEV with the mortgage and, as a result, did not include the amount Petitioner owed on the property. Rather than properly submit verification requests or request more specific information, the caseworker simply processed the application without obtaining what Petitioner owed on the property. This led to a premature determination that Petitioner had exceeded the asset limit for MA and MSP. The Department representative; however, offered to correct the error by recertifying and reprocessing Petitioner's November 19, 2016, application for MA and MSP. Petitioner understood the Department's offer and agreed.

According to BAM 115 (10-1-2016), p. 31, for all programs the Department, as soon as possible, must document and correct benefits approved or denied in error by changing Data Collection, running Eligibility Determination Benefit Calculation (EDBC) and certifying the results. Bridges sends the client a timely or adequate notice as appropriate for department error corrections resulting in:

- Program eligibility or ineligibility.
- Increased or decreased need.
- Higher or lower patient-pay amount.

However, for MA cases, the period of erroneous coverage **cannot** be removed from or reduced in Bridges. BAM 115, p. 32. [Emphasis in original].

For all programs, reinstatement restores a closed program to active status without completion of a new application. Closed programs may be rein-stated for any of the following reasons:

- Closed in error.
- Closed-correct information not entered.
- Timely hearing request.

- Redetermination packet not logged in.
- Hearing decision ordered reinstatement.
- Complied with program requirements before negative action date.
- DHS-1046 manually sent and due date is after the last day of the 6th month.
- Court ordered reinstatement.
- MAGI Medicaid 90 day passive renewals.

See BAM 205 (7-2-2016), p. 1.

This Administrative Law Judge has carefully considered and weighed the testimony and other evidence in the record. The issue was not whether Petitioner exceeded the asset limit for MA and MCS, but whether the Department properly processed Petitioner's application. Prior to the closure of the hearing record, the parties have reached an agreement to resolve this matter. The Department shall reinstate, recertify, and reprocess Petitioner's November 19, 2016, application for health care coverage, which includes MA and MSP benefits. Petitioner acknowledged the above stipulation and expressed satisfaction with the terms of the agreement. Because the parties have mutually reached an agreement to resolve this matter, there is no longer a pending dispute for the Administrative Law Judge to decide. There is no reason for the Administrative Law Judge to provide a detailed policy analysis in this Hearing Decision.

Based on the material, competent, and substantial evidence on the whole record, this Administrative Law Judge finds that the Department acknowledges that it erred when it denied Petitioner's application for health care coverage.

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 did not act in accordance with Department policy when it denied Petitioner's November 19, 2016, application for MA and MSP.

DECISION AND ORDER

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. The Department shall reinstate, recertify and reprocess Petitioner's November 19, 2016, application for health care coverage, including MA and MSP benefits.

2. The Department shall initiate a redetermination of Petitioner's eligibility for MA and MSP benefits back to the date of denial.

3. The Department shall request an expedited ticket to implement the above, if necessary.

4. To the extent required by policy, the Department shall provide Petitioner with retroactive and/or supplemental benefits.

IT IS SO ORDERED.

CAP/mc

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]

Petitioner

[redacted]