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 24, 2017
MAHS Docket No.: 17-004485
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Eric J. Feldman

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 Detroit, Michigan. Petitioner was present for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by [redacted], Hearings Facilitator.

ISSUES

1. Did the Department properly close Petitioner's Medical Assistance (MA) - Healthy Michigan Plan (HMP) coverage effective [redacted]?

2. Did the Department properly deny Petitioner's MA application effective [redacted]?

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 was an ongoing recipient of HMP coverage. [Exhibit A, p. 24.]

2. Petitioner is [redacted] years old; she is not disabled; and her tax composition is one.

3. Petitioner receives biweekly employment earnings (earned income), she works approximately [redacted] hours per biweekly pay period, and she earns $[redacted] an hour. [Exhibit A, pp. 25-27.]

4. On [redacted], Petitioner submitted a Semi-Annual Contact Report.

5. The Department processed Petitioner's submitted Semi-Annual Contact Report and determined she was no longer eligible for HMP coverage due to excess income.

6. On [redacted], the Department sent Petitioner a Health Care Coverage Determination Notice (determination notice) notifying her that she was not eligible for HMP benefits effective [redacted], due to excess income. [Exhibit A, pp. 8-11.]

7. On [redacted], Petitioner applied for MA benefits. [Exhibit A, pp. 13-23.]

8. On [redacted], the Department sent Petitioner a determination notice notifying her that she was not eligible for MA benefits, including HMP benefits, effective [redacted], due to excess income. [Exhibit A, pp. 4-7.]

9. On [redacted], Petitioner filed a hearing request, protesting the Department's action. [Exhibit A, pp. 1-3.]

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.

As a preliminary, the undersigned Administrative Law Judge (ALJ) will address Petitioner's closure of HMP benefits and the denial of her MA application below in the same analysis because it involves the same issue, ineligibility for HMP benefits due to excess income.

MA is available (i) under Supplemental Security Income (SSI)-related categories to individuals who are aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled or (ii) for children under 19, parents or caretakers of children, pregnant or recently pregnant women, former foster children, MOMS, MIChild and HMP based on the Modified Adjusted Gross Income (MAGI) methodology. BEM 105 (October 2016), p. 1. The evidence at the hearing established that the most beneficial MA category available to Petitioner was HMP.

The Healthy Michigan Plan (HMP) is based on Modified Adjusted Gross Income (MAGI) methodology. BEM 137 (October 2016), p. 1. 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 effective April 1, 2014. BEM 137, p. 1.

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 percent Federal Poverty Level (FPL) Cost Sharing.

BEM 137, p. 1.

Before determining whether Petitioner's income is at or below 133% of the FPL, the Department must first determine Petitioner's household composition. The size of the household will be determined by the principles of tax dependency in the majority of cases. MAGI Related Eligibility Manual, *Michigan Department of Community Health* (DCH), May 2014, p. 14. Available at http://michigan.gov/documents/mdch/MAGI_Manual_457706_7.pdf.

In this case, the Department properly determined Petitioner's household composition was one.

The analysis now turns to whether Petitioner's income was at or below 133% of the FPL. The 2016 Poverty Guidelines indicated that the poverty guidelines for persons in family/household size of one is $[redacted] 2016 Poverty Guidelines, *U.S. Department of Health & Human Services*, April 25, 2016, p. 1. Available at: https://aspe.hhs.gov/computations-2016-poverty-guidelines. However, the poverty guidelines for a household size of one must be multiplied by 1.33 (133%) to obtain the 133% FPL calculation. The result is that Petitioner's annual income must be at or below $[redacted] ($[redacted] multiplied by 1.33) of the FPL for a household size of one. For monthly eligibility, the income must be at or below $[redacted] for a household size of one ($[redacted] divided by 12 months).

In this case, Petitioner received biweekly employment earnings that the Department used to make its determination that her income exceeded the limits. As a part of the evidence record, the Department included three of Petitioner's pay stubs as follows: (i) pay date of [redacted], gross income of $[redacted] [redacted] hours worked for biweekly pay, and [redacted] hours of overtime; (ii) pay date of [redacted], gross income of $[redacted] and [redacted] hours worked for biweekly pay; and (iii) pay date of [redacted], gross income of $[redacted] and [redacted] hours worked for biweekly pay. [Exhibit A, pp. 25-28.]

It should be noted that pay date of [redacted], appeared to be associated with the submission of her Semi-Annual Contact Report; and the pay dates of [redacted] and [redacted], appeared to be associated with the submission of her application. The Department testified that Petitioner currently earns $[redacted] per hour and is working 74 to 80 hours per two-week pay period ([redacted] hours x $[redacted] per hour = $[redacted] per pay date x 26 pay periods = $[redacted] in yearly gross wages). [Exhibit A, p. 1.] Thus, the Department argued that Petitioner was not eligible for HMP benefits because her income exceeds the annual HMP income limit of $[redacted] for a household size of one.

In response, Petitioner indicated that she was previously working approximately [redacted] to [redacted] hours per biweekly pay period because she was part-time. Petitioner acknowledged that she worked [redacted] to [redacted] hours as reflected in her pay stubs, but that was only if she was covering someone else's work shift.

Medicaid eligibility is determined on a calendar month basis. BEM 105, p. 2. Unless policy specifies otherwise, circumstances that existed, or are expected to exist, during the calendar month being tested are used to determine eligibility for that month. BEM 105, p. 2. When determining eligibility for a future month, assume circumstances as of the processing date will continue unchanged unless you have information that indicates otherwise. BEM 105, p. 2.

MAGI for purposes of Medicaid eligibility is a methodology which state agencies and the federally facilitated marketplace (FFM) must use to determine financial eligibility. BEM 500 (January 2016), p. 3. It is based on Internal Revenue Service (IRS) rules and relies on federal tax information to determine adjusted gross income. BEM 500, pp. 3-4. It eliminates asset tests and special deductions or disregards. BEM 500, p. 4. Every individual is evaluated for eligibility based on MAGI rules. BEM 500, p. 4. The MAGI rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through exchanges. BEM 500, p. 4.

In order to determine income in accordance with MAGI, a client's adjusted gross income (AGI) is added to any tax-exempt foreign income, tax-exempt Social Security benefits, and tax-exempt interest. AGI is found on IRS tax form 1040 at line 37, form 1040 EZ at line 4, and form 1040A at line 21. Alternatively, it is calculated by taking the "federal taxable wages" for each income earner in the household as shown on the paystub or, if not shown on the paystub, by using gross income before taxes reduced by any money the employer takes out for health coverage, child care, or retirement savings. The figure is multiplied by the number of paychecks the client expects in [redacted] to estimate income for the year. See https://www.healthcare.gov/income-and-household-information/how-to-report/. Additionally for review, is a chart that shows common types of income countable towards a MAGI eligibility determination and with respect to federal taxable wages from employment, a client is to use federal taxable wages if indicated on a paystub and if not, use gross income and subtract amounts your employer takes out of your pay for child care, health insurance, and retirement plans. See https://www.healthcare.gov/income-and-household-information/how-to-report/.

Additionally, federal law provides further guidance in the determination of an individual's financial eligibility for MAGI related categories. Specifically, in determining an individual's financial eligibility for a budget period, 42 CFR 435.603(h)(1) states that for applicants and new enrollees:

> Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

Also, 42 CFR 435.603(h)(2) states for current beneficiaries:

> For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

Finally, 42 CFR 435.603(h)(3) states:

> In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both . . .

Based on the above policy manuals and federal regulations, the Department has established by a preponderance of evidence that Petitioner was not eligible for HMP benefits due to excess income. At the time of Petitioner's Semi-Annual Contact Report and her application, the evidence established that she was working approximately 74 to [redacted] hours per biweekly pay period, with a $[redacted] hourly pay rate. [Exhibit A, pp. 25-27.] Petitioner did not provide any pay stubs showing that she was working less than [redacted] to [redacted] hours per biweekly pay period. When the undersigned takes Petitioner's $[redacted] hourly rate multiplied by her working [redacted] hour per biweekly pay period, this results in a biweekly pay of $[redacted] or $[redacted] for her monthly income ($[redacted] times two). Furthermore, if the undersigned takes Petitioner monthly income amount of $[redacted] and multiplies it by 12 months, the result is an annual income of $[redacted] As a result, Petitioner's annual income exceeds the annual HMP income limit of $[redacted] for a household size of one. The Department had a slightly different method in calculating Petitioner's income, but ultimately, in either method, her income exceeds the HMP income limits.

Accordingly, the Department acted in accordance in Department policy when it determined that Petitioner was not eligible for HMP benefits effective [redacted], due to excess income. BEM 105, p. 2; BEM 137, p. 1; BEM 500, pp. 3-4; 42 CFR 435.603(h)(1) to (3); and MAGI Related Eligibility Manual, pp. 1-51.

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 (i) the Department acted in accordance with Department policy when it properly closed Petitioner's HMP coverage effective [redacted]; and (ii) the Department acted in accordance with Department policy when it properly denied Petitioner's MA application dated [redacted] effective [redacted].

Accordingly, the Department's MA/HMP decision is **AFFIRMED**.

EF/

Eric J. Feldman
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

Petitioner

[redacted]

DHHS

[redacted]