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: June 9, 2017
MAHS Docket No.: 17-003772
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: C. Adam Purnell

HEARING DECISION

Following [redacted] (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 438.400 to 438.424 and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on May 3, 2017, from Lansing, Michigan. [redacted] Hearing Facilitator, and [redacted] Eligibility Specialist, appeared on behalf of the Department of Health and Human Services (Department). Petitioner appeared and testified on her own behalf at the hearing.

ISSUE

Did the Petitioner show that the Department failed to properly determine her co-pay amount and/or the amount of contributions under the Healthy Michigan Plan (HMP)?

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 active for health care benefits and enrolled in the HMP with no requirement for contributions. [Department's Exhibit B & Petitioner's Hearing Testimony.].

2. Petitioner was unemployed and had $[redacted] income during all relevant times. [Petitioner's Hearing Testimony].

3. Effective on or about February 9, 2016, Petitioner began receiving MI Health Account Statements, which indicated that she had no requirement for contributions concerning her HMP benefits. [Pet. Hrg. Test.].

4. On November 9, 2016, Petitioner received a MI Health Account Statement, which indicated that she owed $[redacted] in contributions for the next 3 months. The statement indicates, "[y]ou will not pay more than 5% of your income for your coverage." The bottom of the MI Health Account Statement directed recipients to call a Beneficiary Help Line (1-800 number) for questions. [Pet. Exh. 1, pp. 1-2.]

5. Petitioner made repeated telephone calls to the Beneficiary Help Line and was informed that the she should contact her departmental local office caseworker for assistance. [Pet. Hrg. Test.].

6. On or about January 20, 2017, Petitioner called the Beneficiary Help Line again and was advised that the records indicated Petitioner had $[redacted] in annual income. Petitioner stated that this was an error because she had $[redacted] income. The Beneficiary Help Line again referred Petitioner to her departmental local office caseworker to correct the error in her HMP case. [Dept. Exh. 1, p. 2 & Pet. Hrg. Test.].

7. On February 14, 2017, Petitioner received another MI Health Account Statement, which indicated that she owed an additional $[redacted] in contributions on her HMP case. [Pet. Exh. 1, pp. 9-18.]

8. On March 14, 2017, Petitioner requested a hearing to dispute the contributions amount and to correct the HMP error. [Request for Hearing].

9. The hearing took place on May 3, 2017.

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 438, MCL 400.10, and MCL 400.105-.112k.

The Healthy Michigan Plan (HMP) provides health care coverage for a category of eligibility authorized under the Patient Protection and Affordable Care Act 1902(a)(10)(A)(i)(VIII) of the Social Security Act and Michigan Public Act 107 of 2013 effective April 1, 2014. BEM 137 (1-1-2016), p. 1.

The Healthy Michigan Plan 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.

BEM 137, p. 1.

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. BEM 137, p. 1.

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. BEM 137, p. 2.

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. BEM 137, p. 2.

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. BEM 137, p. 2.

In order to be eligible for HMP, the individual must be aged 19 or older and under age 65 and have income limits at or below 133 percent of the federal poverty limit. See 42 CFR § 435.119 (b). The Health Care Coverage Determination Notice provides a chart of the annual income limits for HMP. BEM 137, p. 2.

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. BEM 137, p. 2.

Parents requesting health care coverage for themselves must provide proof that their children have credible coverage, even if not applying for the children. BEM 137, p. 2.

Credible coverage is health insurance coverage under any of the following:

- Group health plan, individual or student health insurance.
- Medicare or Medicaid.
- TRICARE/CHAMPUS.
- CHIP (MIChild in Michigan).
- Federal Employees Health Benefit Program.
- Indian Health Service.
- Peace Corps.
- Public Health Plan (any plan established or maintained by a State, the U.S. government, or a foreign country)
- A state health insurance high-risk pool.

BEM 137, p. 3.

Modified Adjusted Gross Income (MAGI) is a methodology used to determine financial eligibility for Medicaid. It is based on Internal Revenue Service rules and relies on federal tax information. Bridges Program Glossary (BPG) (10-1-2015), page 40.

MAGI for purposes of Medicaid eligibility is a methodology which state agencies and the federally facilitated marketplace (FFM) must use to determine financial eligibility. It is based on Internal Revenue Service (IRS) rules and relies on federal tax information to determine adjusted gross income. It eliminates asset tests and special deductions or disregards. BEM 500 (1-1-2016), pp. 3-4.

Every individual is evaluated for eligibility based on MAGI rules. 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.

According to the Modified Adjusted Gross Income (MAGI) Manual 1.1 (May 28, 2014), the local office must do all of the following; determine eligibility, calculate the level of benefits, and protect individual rights. HMP eligibility is determined through a Modified Adjusted Gross Income (MAGI) methodology, which includes an evaluation of the applicant's income. (MAGI) Eligibility Manual 1.1 (May 28, 2014).

At the hearing, Petitioner indicated that she had requested a hearing to challenge an alleged incorrect premium or contribution amount that had been assessed on her Healthy Michigan Plan (HMP) case. Petitioner stated that she had no income at any time. The Department representatives took the position that the local office only determines HMP eligibility and that Petitioner's only recourse was to contact the entity who manages her HMP account. The Department representatives did admit that an error occurred with regard to Petitioner's HMP case. According to the Department, Bridges had incorrectly included Petitioner's 2014 income and applied it to her MAGI calculation. The Department requested a ticket to correct the MAGI determination. The Department representatives indicated that Petitioner was directed to contact the Beneficiary Help Line after the ticket was resolved. Accordingly, the Department argued that no negative action had been taken by the local office concerning Petitioner's HMP case.

Pursuant to 42 CFR 438.400(a)(1), a State plan is required to "provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly." Further, Medicaid managed care organizations are required to "establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance." 42 CRF 438.400(3). Here, there is no dispute that Petitioner is entitled to a fair hearing because she requested assistance concerning an alleged incorrect or inaccurate HMP contribution amount.

Although the Department contends that the local office does not handle HMP contribution claims and that no negative action took place, this Administrative Law Judge does not agree that no negative action occurred in this matter. The Department representatives conceded that, at one time, Petitioner's MAGI income was erroneous based on outdated information from 2014. Clearly, Petitioner's HMP case, which is managed under the umbrella of the Department of Health and Human Services, was negatively affected when she was assessed a premium (or a new contribution) based on erroneous MAGI income information. Based on 42 CFR 431.220 cited above, Petitioner is entitled to a hearing to dispute this negative assessment action.

This Administrative Law Judge has carefully considered and weighed the testimony and other evidence in the record. As indicated above, the Department's position that there was no negative action taken by the local office is not persuasive. The issue before this Administrative Law Judge is whether Petitioner has met her burden of proof to show that the Department erred concerning the calculation of her HMP contribution amount.

Generally, the proponent of the order in question has both the burden of going forward with evidence in support of its position. *Bunce v Secretary of State*, 239 Mich App 204,

216, 607 NW2d 372, 377-78 (1999). An individual who seeks to obtain government benefits is generally the proponent and carries the burden of going forward. *In re Sprint Communications Co., L.P., Complaint*, 234 Mich 22; 592 NW2d 825 (1999). However, the Department makes the determinations concerning HMP contribution amounts and possesses the related documentation.

Department policy does not specifically indicate that the Department has the burden of proof. However, BAM 600 (10-1-2016), pp. 35-36, indicates that the Administrative Law Judge must determine whether the actions taken by the local office are correct according to fact, law, policy and procedure. The Department's local office must provide sufficient evidence to enable the Administrative Law Judge to ascertain whether the Department followed policy in a particular circumstance. In other words, 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. In order for the Administrative Law Judge to make this determination, the Department must provide evidence to support its actions. However, the Petitioner does have the ultimate burden of proof to show that she is eligible for the benefits she seeks.

Here, Petitioner was previously determined to be eligible for HMP benefits, but she contends that an error occurred regarding her HMP contribution amount. Petitioner's testimony at the hearing that she received erroneous HMP contribution amounts on her case was credible and she provided exhibits which corroborated her statements. The record showed that Petitioner did not have any income at the time and her initial HMP case indicated that she did not have any contributions or premiums. The Department did not disagree with this contention. However, Petitioner's HMP case was later erroneously calculated which resulted in letters being sent to her that indicated she had premiums. There was no dispute that Petitioner's income was erroneously calculated and the Department representatives did not refute this contention. The Department representatives stated at the hearing that no negative action had been taken and that Petitioner's sole recourse is the 1-800 Help Line indicated on the HMP correspondence. However, when Petitioner called the 1-800 Help Line, she was told that the Department's local office handles this issue. The undersigned believes that the Department did take negative action concerning her HMP case and that Petitioner is entitled to a hearing based on 42 CFR 438. Here, the undersigned Administrative Law Judge finds that the Department failed to go forward with sufficient evidence to show a proper basis for its negative action, while Petitioner met her ultimate burden of proof to show that the Department's negative action was in error.

Based on the material, competent, and substantial evidence on the whole record, this Administrative Law Judge finds that the Petitioner sufficiently showed that the Department failed to properly determine the contribution amount for purposes of her HMP benefits case.

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

show that it acted in accordance with Department policy when it determined Petitioner's HMP premium or contribution amounts.

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. Redetermine and recalculate Petitioner's HMP contribution amounts going back to November 2016.

2. After the Department redetermines and recalculates the above, the Department shall issue Petitioner with written communication detailing its findings.

3. 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]