STATE OF MICHIGAN
RICK SNYDER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: August 1, 2017
MAHS Docket Nos.: 17-007208; 17-008321
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; 42 CFR 438.400 to 438.424; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, a three-way telephone hearing was held on [redacted], from Detroit, Michigan. Petitioner was present for the hearing and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payments Supervisor (Adult Medical office location); and [redacted], Assistance Payments Worker ([redacted] office location).

ISSUES

1. Did the Department properly provide Petitioner with Medical Assistance (MA) coverage she is eligible to receive from [redacted], ongoing?

2. Did the Department properly process Petitioner's MA case and medical bills for [redacted]?

3. Did the Department properly close Petitioner's MA benefits 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 MA - Group 2 Spend-Down (G2S) benefits.

2. For [redacted], Petitioner received G2S coverage, subject to a $[redacted] deductible. [Exhibit C, pp. 2 and 15.]

3. For [redacted], Petitioner received G2S coverage, subject to a $[redacted] deductible. [Exhibit C, p. 15.]

4. On [redacted], the Department received medicals bills for Petitioner. [Exhibit A, pp. 5-6, and Exhibit D, pp. 1-2.]

5. On [redacted], the Department sent Petitioner a Health Care Coverage Determination Notice (determination notice) notifying her that she was eligible for MA coverage from [redacted] subject to a $[redacted] deductible; and she was found eligible for full MA coverage from [redacted]. The determination notice stated that she was responsible to pay $[redacted] to "Provider1" for services received on [redacted]. [Exhibit C, pp. 2-5.]

6. On [redacted], the Department sent Petitioner a determination notice notifying her that she was not eligible for MA coverage effective [redacted], ongoing because her deductible had not been met in at least one of the last three months. [Exhibit C, pp. 7-10.]

7. On [redacted], Petitioner filed a hearing request, protesting the determination notice dated [redacted]. [Exhibit A, pp. 3-4.]

8. On [redacted], Petitioner filed a hearing request, protesting the determination notice dated [redacted]. [Exhibit B, pp. 2-3.]

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.

Preliminary matter

In this case, Petitioner filed two separate hearing requests concerning the Department's actions related to her MA benefits. As a result, two separate administrative hearings were scheduled. The undersigned Administrative Law Judge (ALJ) consolidated both hearings scheduled into one administrative hearing and issued this one hearing decision to address both Docket Nos.: 17-007208 and 17-008321. For Docket No. 17-007208, Petitioner filed a hearing request on [redacted], protesting her MA benefits/medical bills for [redacted]. [Exhibit A, pp. 3-4.] For Docket No. 17-008321, Petitioner filed a hearing request on [redacted], protesting the closure of her MA benefits effective [redacted]. [Exhibit B, pp. 2-3.] The undersigned will address each issue separately below:

Most Beneficial Program (Docket No. 17-007208)

On [redacted], Petitioner also filed a hearing request, in which she claimed that "[d]ue to disability, should be eligible for Disability Medicaid." [Exhibit A, pp. 3-4.] The undersigned interprets this to mean that she argues that the deductible coverage provided by the Department was inadequate. In this case, Petitioner receives a net total income of approximately $[redacted] from both her Retirement, Survivors and Disability Insurance (RSDI) income and long-term disability income, her MA group size is one; and she receives Medicare benefits.

Persons may qualify under more than one MA category. BEM 105 (April 2017), p. 2. Federal law gives them the right to the most beneficial category. BEM 105, p. 2. The most beneficial category is the one that results in eligibility, the least amount of excess income or the lowest cost share. BEM 105, p. 2.

Based on the foregoing information, the evidence and testimony is persuasive to conclude that the Department acted in accordance with Department policy when it processed Petitioner's eligibility for the most beneficial MA category for [redacted] ongoing. BEM 105, pp. 2-5. In this case, Petitioner is not eligible for full MA coverage under the AD-Care program due to excess income. BEM 163 (July 2013), pp. 1-6; and RFT 242 (April 2017), p. 1, (AD-Care income limits). Instead, Petitioner's most beneficial MA category was G2S, subject to a deductible, based on the evidence and testimony presented.

Deductible for February 2017 (Docket No. 17-007208)

G2S is a Supplemental Security Income (SSI)-related Group 2 MA category. BEM 166 (July 2013), p. 1. MA is available to a person who is aged (65 or older), blind or disabled. BEM 166, p. 1. All eligibility factors must be met in the calendar month being tested. BEM 166, p. 1. Income eligibility exists when net income does not exceed the Group 2 needs in BEM 544. BEM 166, p. 2. If the net income exceeds Group 2 needs, MA eligibility is still possible per BEM 545. BEM 166, p. 2.

As stated in the previous analysis, Petitioner's most beneficial MA category was G2S; but due to her net income exceeding the limits, her benefits were subject to a deductible. For [redacted], Petitioner received G2S coverage, subject to a $[redacted] deductible. [Exhibit C, pp. 2 and 15.] On [redacted], Petitioner's following medical bills were reported to the Department:

- [redacted], $[redacted] incurred for services rendered from [redacted];
- [redacted], $[redacted] incurred for services rendered from [redacted];
- [redacted], $[redacted] incurred for services rendered for [redacted]; and
- Undated [redacted] pharmacy bills totaling $[redacted]

[Exhibit A, pp. 5-6, and Exhibit D, pp. 1-2.]

The Department processed the submitted medical bills; and on [redacted], the Department sent Petitioner a determination notice notifying her that she was eligible for MA coverage from [redacted], subject to a $[redacted] deductible; and she was found eligible for full MA coverage from [redacted]. The determination notice stated that she was responsible to pay $[redacted] to "Provider1" for services received on [redacted]. [Exhibit C, pp. 2-5.] Despite the determination notice stating she had full coverage from [redacted], the Department's Hearing Summary stated she did not meet her deductible for [redacted] because her deductible is $[redacted] and the medical bills only totaled $[redacted] for the month of February 2017 from Community Care Services. [Exhibit A, p. 1.]

In response, Petitioner filed a hearing request arguing that she did meet her deductible for [redacted]. [Exhibit A, p. 3.] The undersigned inquired from Petitioner if she met her deductible, and she was not sure. She testified that she was hospitalized in [redacted] but did not have any medical bills from that hospitalization nor did she present any medical bills for the hearing.

The Department also presented a "Medical Expenses – Summary," which shows a history of any medical bills that she would have submitted to the Department. However, the undersigned did not find any additional medical bills that were incurred for [redacted] [Exhibit C, pp. 11-13.] At first glance, it appears that Petitioner did not meet her deductible for [redacted]. However, the undersigned concerns are the contradictory information the Department presented in which some documents show that she did meet her deductible and other documents that say she did not for [redacted] For example, the determination notice shows she meet her deductible from [redacted]. [Exhibit C, pp. 2-5.] Also, her "MA-EDG Summary" document showed that she had full Medicaid coverage for [redacted]

but a review of her medical expenses shows that she did not meet her deductible. [Exhibit C, pp. 11-14.]

Income eligibility exists for the calendar month tested when: (i) there is no excess income or allowable medical expenses equal or (ii) exceed the excess income. BEM 545 (January 2017), p. 1.

When one of the following equals or exceeds the group's excess income for the month tested, income eligibility exists for the entire month: (i) Old bills; (ii) Personal care services in clients home, Adult Foster Care (AFC), or Home for the Aged (HA); (iii) Hospitalization; or (iv) Long-Term Care. BEM 545, p. 1.

When one of the above does not equal or exceed the group's excess income for the month tested, income eligibility begins either: (i) the exact day of the month the allowable expenses exceed the excess income; or (ii) the day after the day of the month the allowable expenses equal the excess income.

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, pp. 2-3. 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. BEM 545, p. 10. Each calendar month is a separate deductible period. BEM 545, p. 10. The fiscal group's monthly excess income is called a deductible amount. BEM 545, p. 11. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month tested. BEM 545, p. 11. The Department sends the group a DHS-1606, determination notice, when you:

- Approve or deny MA.
- Add periods of MA coverage to an active deductible case.
- Transfer an active deductible case to ongoing MA coverage.

BEM 545, p. 14.

Based on the foregoing information and evidence, the Department failed to satisfy its burden of showing that it properly processed Petitioner's MA case and medical bills for [redacted]. In this case, the undersigned is unable to determine if Petitioner met her deductible for [redacted]. As shown above, policy states that the Department sends a determination notice when the Department adds periods of MA coverage to an active deductible case, which is what occurred in this instance when she received notice that she received full MA coverage for [redacted] [Exhibit C, pp. 2-5.] Yet, the Department argues that she did not meet her deductible for the month of [redacted]. Because the Department presented contradictory information and the undersigned is unable to make a determination that she met her deductible, the Department failed to satisfy it burden of showing that it properly processed Petitioner's MA

case and medical bills for [redacted]. The Department is ordered to reprocess her case, including her medical bills, and determine if she met her deductible for [redacted] in accordance with Department policy. See BEM 545, pp. 1-32.

MA Closure (Docket No. 17-008321)

Petitioner's final issue was the determination notice dated [redacted], which notified her that she was not eligible for MA coverage effective [redacted], ongoing because her deductible had not been met in at least one of the last three months. [Exhibit C, pp. 7-10.]

Policy states that the Department renews eligibility for active deductible cases at least every 12 months unless the group has not met its deductible within the past three months. BEM 545, p. 12. If a group has not met its deductible in at least one of the three calendar months before that month and none of the members are Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), or Q1 Additional Low-Income Medicare Beneficiaries (ALMB), the Department will automatically notify the group of closure. BEM 545, p. 12.

Based on the foregoing information and evidence, the Department failed to satisfy it burden of showing that it properly closed Petitioner's MA benefits effective [redacted]. Policy does state that if the deductible had not been met in at least one of the last three months, then the benefits will close. BEM 545, p. 12. The Department argues that Petitioner did not meet her deductible for [redacted] [redacted] and [redacted]. Therefore, when it processed her case for [redacted], it sent her a determination notice on [redacted], which notified her that her MA benefits would close effective [redacted] However, as shown above in the deductible analysis, the undersigned is unable to determine if Petitioner met her deductible for [redacted]. Because the Department failed to satisfy its burden of showing whether or not she met her deductible for [redacted], the Department is also unable to satisfy its burden of showing that she did not meet her deductible in at least one of the last three months in order to justify her closure for [redacted]. The Department must first process the undersigned's order to determine if she met her deductible for [redacted]; and then once processed, the Department can then determine if she met her deductible in at least one of the last three months.

Accordingly, because the Department failed to satisfy its burden of showing whether or not she met her deductible for [redacted], the Department also failed to satisfy its burden of showing that it properly closed her MA benefits effective [redacted], on the basis that that she did not meet her deductible in at least one of the last three 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 (i) the Department acted in accordance with Department policy when it processed Petitioner's eligibility for the most beneficial MA category for [redacted], ongoing (Docket No. 17-007208); (ii) the Department failed to satisfy it burden of showing that it properly processed

Petitioner's MA case and medical bills for [redacted] (Docket No. 17-007208); and (iii) the Department failed to satisfy it burden of showing that it properly closed Petitioner's MA benefits effective [redacted] (Docket No. 17-008321).

Accordingly, the Department's decision is **AFFIRMED IN PART** with respect to eligibility for the most beneficial MA category for [redacted], ongoing and **REVERSED IN PART** with respect to MA eligibility/medical bills for [redacted] and closure of her MA benefits effective [redacted].

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. Reprocess Petitioner's submitted medical bills in accordance with Department policy;

2. Redetermine Petitioner's MA eligibility for [redacted];

3. Issue supplements to Petitioner for any MA benefits she was eligible to receive but did not for [redacted];

4. Redetermine Petitioner's MA eligibility for [redacted];

5. Issue supplements to Petitioner for any MA benefits she was eligible to receive but did not for [redacted], ongoing; and

6. Notify Petitioner of its decision.

EJF/jaf

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

DHHS [redacted]

DHHS [redacted]

Petitioner [redacted]