[redacted]

Date Mailed: August 30, 2017
MAHS Docket No.: 17-006214
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 August 3, 2017, from Detroit, Michigan. The Petitioner was represented by [redacted]. The Petitioner's wife, [redacted] also appeared as a witness. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Liaison.

ISSUE

Did the Petitioner properly show that the Department failed to properly determine the Petitioner's Healthy Michigan Plan (HMP) copay amounts and contribution amount?

Did the Department properly determine that the Petitioner is eligible for HMP rather than Ad Care Medicaid?

FINDINGS OF FACT

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

1. At the time of the hearing the Petitioner is a married male who is [redacted] years of age, with no dependents under the age of [redacted]

2. The Petitioner completed a Medicaid redetermination for October 3, 2016. The Petitioner reported that has no income. Exhibit A, p. 38.

3. At the redetermination review, the Department found Petitioner eligible for the Health Michigan Plan (HMP) effective October 1, 2016. The Petitioner had previously been eligible for Ad Care full coverage Medical Assistance.

4. The Department issued a Health Care Coverage Determination Notice dated November 28, 2016 which indicated Petitioner was eligible for full coverage MA ongoing effective November 1, 2016. The Department at the hearing advised that it had approved the Petitioner for HMP. Exhibit B, p. 11.

5. The Petitioner's wife received RSDI in the amount of $[redacted] through December 1, 2016. The Department determined the income for the Petitioner based upon his wife's income and that the income for the MA group was $[redacted] as of January 1, 2017. The Petitioner has no income on his own behalf. The Petitioner's wife and attorney for Petitioner confirmed these amounts as correct.

6. Based upon the Petitioner's group MA income of $[redacted] (2016) and $[redacted] (2017) the Petitioner was income eligible for HMP for 2016 and 2017. The Petitioner's wife has Medicare coverage and does not receive any MA benefits from the Department.

7. The Petitioner was required to make a copayment for the HMP benefits. See Petitioner Exhibit 1 and Petitioner Exhibit 2.

8. On April 11, 2017, the Petitioner received an HMP Statement which assessed a monthly contribution of $[redacted] to cover copays of $[redacted] and Contributions of $[redacted] for a total of $[redacted] Petitioner Exhibit 2.

9. The Petitioner received a Healthy Michigan Plan Statement for July 13, 2017, which indicated that the co-pay was $[redacted] and the Contributions were $[redacted] for a total of $[redacted] Petitioner Exhibit 1. For the next 3 months going forward the monthly amount of contribution was $[redacted] and payment coupons were attached. The Payments were $[redacted] because the prior 3 months (April, May and June) had not been received and thus included past due amounts for payments not received. Petitioner Exhibit 2.

10. The Petitioner's attorney filed a timely request for hearing on May 1, 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 435, MCL 400.10, and MCL 400.105-.112k.

An issue of timeliness of the Petitioner's hearing request was raised, by MAHS after receiving the Hearing Request dated May 1, 2017, however, it is determined that the Petitioner's counsel's hearing request was timely because it was received May 1, 2017 and the first statement regarding HMP contributions and copayments was received by Petitioner on April 11, 2017. Based upon these dates the Petitioner's Hearing Request is timely as it was filed within 90 days of receipt of the HMP statement. BAM 600 (January 2017), p. 7.

In this case, the Department changed the Petitioner's Medical Assistance from Ad Care to Healthy Michigan Plan. The reason for the change was due to the Petitioner and his wife receiving a lump sum payment from her brother's insurance of $[redacted] Petitioner's Exhibit 4. This lump sum was received by Petitioner and his wife on August 1, 2016. This payment caused the Petitioner's group assets to be considered as exceeding the MA asset limit for Ad Care for a Group of 2 which is $[redacted] BEM 400 (July 2017), p. 8. Because the Petitioner's MA group's income did not exceed the HMP limit, and because the HMP health care program does not have an asset limit, the Department provided MA coverage under the HMP program as that was the program the Petitioner was eligible for.

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 (January 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.

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.

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).

The Petitioner also challenged the assessment of copay and contributions under the HMP program. After receiving an HMP Statement in April 2017 the Petitioner's wife called the Beneficiary Help Line and was told to contact her worker. The Petitioner's worker told her there was essentially nothing she could do about the copays or contributions. 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.

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 he 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 this Administrative Law Judge does not agree. Clearly, Petitioner's HMP case, which is managed under the umbrella of the Department of Health and Human Services, was negatively affected when he was assessed a premium (or a new contribution) and the contribution was challenged. The Department did not provide any information regarding the MAGI income information it used or how the co-pay and contribution were determined. Based on 42 CFR 431.220 cited above, Petitioner is entitled to a hearing to dispute this negative assessment action.

Overview of Cost-Sharing Obligations and MAGI Income Policy

As previously referenced, copayments for services may apply to HMP beneficiaries under its beneficiary cost sharing requirements which include both co-pays and contributions. The HMP contributions are based upon monthly income and group size.

HMP beneficiaries at 100% to 133% of the FPL are required to pay a monthly contribution into a MI Health Account. See Michigan Department of Community Health (DCH) – Medical Services Administration (MSA) bulletin no. MSA 14-11, February 27, 2017, p. 4. Available at: http://www.michigan.gov/documents/mdch/blank_page_448984_7.pdf. The contribution will be required after the first six months of enrollment and will be based on 2% of the HMP beneficiary's annual income. See MSA bulletin no. 14-11, p. 4. If a MI Health Account is maintained for a HMP managed care member, cost-sharing obligations, which include copays and additional contributions based on a beneficiary's income level, will be satisfied by and monitored through the MI Health Account by the health plan. BEM 137, p. 2.

Thus, there is no question that Petitioner is required to pay a monthly contribution amount.

There was no evidence that after Petitioner's wife's phone call to the help line that Petitioner's wife ever received an Adverse Benefit Determination or Notice of Resolution. Therefore, the Petitioner's only remedy to dispute the cost sharing obligations at the time was to contact the 1-800 help Line and / or the Department.

No evidence was presented regarding what income the Department utilized with regard to determining HMP eligibility. However, for 2017 the monthly income for the Petitioner's MA group was $[redacted] which when multiplied by 12 totals $[redacted]

Pursuant to 42 CFR 431.201, MA applicants and beneficiaries have a right to a Medicaid hearing as a result of an action, which means a reduction, suspension, termination or denial of Medicaid eligibility or covered service. A managed care organization (MCO) which services HMP beneficiaries, must give an HMP beneficiary timely written notice of an adverse benefit determination, which includes "[t]he denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." 42 CFR 438.400(b)(7). Upon receipt of such a notice, the HMP beneficiary is entitled to appeal the adverse benefit determination and to have the MCO timely respond to the appeal. 42 CFR 438.408(a) and (b)(1)-(2). If the MCO fails to adhere to the timeframe, the HMP enrollee is deemed to have exhausted her appeals process and the enrollee may initiate a State fair hearing. 42 CFR 438.408(c)(3) and (f)(1)(i).

Here, there is no dispute that Petitioner is entitled to a fair hearing. The undersigned finds that Petitioner is deemed to have exhausted her appeals process because she was not notified by the MCO how she could appeal the cost-sharing decision and received no assistance to her inquiries. Therefore, Petitioner has been unable to resolve his issues concerning the cost-sharing obligations; and he is entitled to request a State fair hearing under 42 CFR 438.408(c)(3) and (f)(1)(i).

Here, there is no dispute that Petitioner is entitled to a fair hearing. The undersigned finds that Petitioner is deemed to have exhausted his appeals process because he was not notified by the MCO how he could appeal the cost-sharing decision and received no assistance to his inquiries about the co-pay and contributions and how they were determined. Therefore, Petitioner has been unable to resolve his issues concerning the cost-sharing obligations; and se is entitled to request a State fair hearing under 42 CFR 438.408(c)(3) and (f)(1)(i).

As stated above, Petitioner is entitled to a fair hearing to dispute her cost-sharing obligations. However, the Department failed to satisfy its burden of showing that it properly determined Petitioner's cost-sharing obligation under the HMP coverage effective April 11, 2017, ongoing. The undersigned has carefully considered and weighed the testimony and other evidence in the record. BAM 600 indicates that the undersigned must determine whether the actions taken by the local office are correct according to fact, law, policy and procedure. BAM 600 (April 2017), p. 36. As such, the undersigned finds that the Department failed to show that it acted in accordance with Department policy when it determined Petitioner's cost sharing obligations effective

January 1, 2017, and thus did not meet it burden of proof. Therefore, the Department is ordered redetermine and recalculate Petitioner's HMP cost-sharing obligation amounts going back to April 11, 2017. Petitioner Exhibit 1 and 2.

Counsel for Petitioner also argued that Petitioner was eligible to be a waiver patient, however no proof was presented that the Petitioner was ever approved as a waiver patient was made by the agency in charge of making that determination. BEM 402 (January 2017), p. 2. The waiver status was sought on behalf of Petitioner so that the Ad Care asset limit would not apply. The Attorney for Petitioner asserted that Petitioner was LH (nursing home) eligible and was approved as a waiver patient. However, because no proof that the Petitioner qualified as a waiver patient was provided, the Department correctly determined Petitioner eligible for HMP based upon the information available to it at the time of its determination.

At the hearing, the Petitioner's counsel also presented a Probate Court Order for Protection under 42 USCA Section 1396r-5. The Order transfers all of the assets, to the Petitioner's wife. Petitioner Exhibit 4. This Order was not made available to the Department until the hearing and therefore, the Department's actions placing the Petitioner on the HMP program is determined to be correct based upon the information available to it at the time of its determination. While this issue may raise a question as to whether the Petitioner is now asset eligible, that question is not before the undersigned. BEM 402 (January 2017), p. 10-11.

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 the Petitioner's cost sharing obligations for purposes of his HMP benefits case effective April 11, 2017 cost sharing Statement.

DECISION AND ORDER

Accordingly, the Department's decision is

AFFIRMED IN PART with respect to its determination that Petitioner was eligible for HMP and that his assets exceeded the Ad Care asset limit and,

REVERSED IN PART with respect to its determination regarding the HMP co-payment and contribution amounts ongoing beginning April 11, 2017.

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 cost sharing obligation amounts, for co-pay and contributions going back to January 1, 2017;

2. After the Department redetermines and recalculates the above, the Department shall issue Petitioner and Petitioner's Attorney written communication detailing its findings; and

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

LF/hw

Lynn M. Ferris
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]

Counsel for Respondent

[redacted]

Petitioner

[redacted]