[redacted]

Date Mailed: October 3, 2017
MAHS Docket No.: 17-010241
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 telephone hearing was held on September 26, 2017, from Detroit, Michigan. The Petitioner was represented by [redacted], Authorized Hearing Representative. The Petitioner also attended the hearing. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Facilitator.

ISSUE

Did the Department properly decline to process the Petitioner's submission of Medicaid Deductible Monthly Statement of Cost because it was not a bill or receipt from the medical provider as required by Department policy?

Did the Department properly determine that the Petitioner was ineligible for the [redacted] Program?

FINDINGS OF FACT

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

1. The Petitioner receives RSDI and is working.

2. The Petitioner is currently eligible for Group 2 MA with medical deductible which varies by month. Exhibit 2 and 3.

3. The Department issued a Health Care Coverage Determination Notice on March 15, 2017 advising the Petitioner of his Medical Assistance Deductible amount and dates the deductible were met through January 9, 2017. Exhibit 2

4. The Department issued a Health Care Coverage Determination Notice on July 26, 2017 which advised the Petitioner that his deductible for April 1, 2017 was [redacted] and that he was eligible for Medicaid (full coverage) on April 11, 2017. Exhibit 3.

5. The Petitioner requested that his request be processed to determine whether he was eligible for the [redacted] program in June 2017. The Petitioner is working and is disabled and receives RSDI.

6. The Petitioner's Authorized Hearing Representative (AHR) requested a timely hearing on July 26, 2016.

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.

In this case, the Petitioner currently receives Group 2 MA with a deductible which varies. The Petitioner's AHR has sought to have the services he receives as a Mental Health Services recipient be included as a medical expense to meet his deductible. The Petitioner's AHR submitted what she described as bills which were previously submitted to the Department on Petitioner's behalf for the Department to count towards the Petitioner's monthly deductible amount. The Department in its Hearing Summary explained that the Department requires that the actual bills that are submitted to them to be from the service provider. The service provider is [redacted] and no bill, invoice or receipt from the medical provider was submitted to the Department for review and processing. Apparently, the Department explained at the Prehearing Conference held in this case that the Department needs an actual bill or receipt to verify that an expense has been incurred. The Statement of Cost submitted by the Petitioner's AHR, from [redacted]. does not meet this requirement as it is only a

summation of all costs incurred but is not an actual bill for services that an individual would receive from his doctor or other provider.

In this case the Petitioner has a deductible which varies and 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, (January 2017), p. 8

The Department policy found in BEM 545 addresses the submission and requirements for allowable medical expenses to meet a deductible when one of the following equals or exceeds the group's excess income for the month tested:

- Old bills (defined in EXHIBIT IB).
- Personal care services in clients home, (defined in Exhibit ID), Adult Foster Care (AFC), or Home for the Aged (HA) (defined in EXHIBIT ID).
- Hospitalization (defined in EXHIBIT IC).
- Long-term care (defined in EXHIBIT IC).

When **one** of the above does **not** equal or exceed the group's excess income for the month tested, income eligibility begins either:

- **The exact day of the month** the allowable expenses **exceed** the excess income.
- **The day after the day of the month** the allowable expenses **equal** the excess income. BEM 545, (January 2017), p. 1

In order for the Department to process a bill for a medical expense, verification requirements in BEM 545 must be met:

Verify the following **before** using an allowable medical expense to determine eligibility:

- Date expense incurred.
- Amount of expense.
- Current liability for an old bill.
- Receipt of personal care services provided in a home, an adult foster care home, or home for the aged; see EXHIBIT ID or Exhibit II if verifying ongoing eligibility.

Verify both of the following when you authorize MA based on a personal care co-payment:

- Amount DHHS has authorized for personal care services.
- Amount required but not covered by DHHS payment.

See EXHIBIT II in this item.

Verification Sources

Sources to verify an incurred expense include:

- Bill from medical provider.
- Receipt from medical provider.
- Contact with medical provider or the provider's billing service.

Sources to verify current liability for an old bill include:

- Current billing or statement from provider.
- Contact with medical provider or provider's billing service. EBEM 545, p. 16-17.

Based upon the information submitted to the Department and testimony by the Petitioner's AHR it is clear that the way the medical expenses were submitted are not acceptable under Department policy. The monthly statement of cost is not a bill or receipt from the medical provider who provided the services to Petitioner. The Petitioner's AHR admitted that the provider was [redacted] and no bills for their services were submitted. Therefore, the Department correctly declined to process the monthly statement of costs which was submitted.

Eligibility for [redacted]

The [redacted] program is medical assistance for clients who meet the following eligibility requirements: FTW is available to a client with disabilities age 16 through 64 who has earned income.

Eligibility begins the first day of the calendar month in which all eligibility criteria are met. All eligibility factors must be met in the calendar month being tested.

Note: SSI recipients whose SSI eligibility has ended due to financial factors are among those who should be considered for this program.

NON-FINANCIAL ELIGIBILITY FACTORS

1. The client must be disabled according to the disability standards of the Social Security Administration, except employment, earnings, and substantial gainful activity (SGA) cannot be considered in the disability determination.

   Note: FTW clients requiring a disability determination from Disability Determination Service (DDS) must be clearly indicated on the medical packet by checking the other Program box and writing [redacted]" or [redacted]" on the cover sheet.

2. The client must be employed. [redacted] coverage is retained when a participant is relocated due to employment.

   Note: A client may have temporary breaks in employment up to 24 months if the break is the result of an involuntary layoff or is determined to be medically necessary and retain [redacted] eligibility. Use client statements to verify. BEM 174 (January 2017), p. 1.

Income eligibility exists when the client's countable income does not exceed 250% of the Federal Poverty Level. A premium payment of 2.5% of income will be charged for an individual with MAGI income between 138% of the FPL and $75,000 annually. There are no premiums for individuals with MAGI (Modified Adjusted Gross Income) less than 138% of the FPL.

In this case the Department testified that the [redacted] program requires that the client be an SSI recipient or that the program was for SSI group 1 MA recipients. Department policy states that this is an SSI related Group 1 MA category which means it has no deductible associated with it. See BEM 105, (April 2017), p. 1 which describes the difference between Group 1 and Group 2 SSI related Medicaid. Based upon the fact that the Petitioner is disabled and receiving RSDI and is also working, the Department's evidence did not suggest that his request for this program was processed or considered other than to say the Bridges will automatically determine if Petitioner is eligible for [redacted]. Given the evidence presented at the hearing, it is determined that the Department did not meet its burden of proof to establish that the Petitioner's eligibility for the [redacted] program was considered and denied, and no basis for the denial if any, was provided. Clients who qualify under more than one

MA category have the right to choose the most beneficial category; see BAM 105, (October 2017), p. 15.

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 acted in accordance with Department policy when it did not accept the statement of costs as a medical expense as it was not a bill or receipt from the medical provider.

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 to process and determine the Petitioner's eligibility for the [redacted] program.

DECISION AND ORDER

Accordingly, the Department's decision is

AFFIRMED IN PART with respect to the medical statement of cost submitted not being an acceptable medical bill or receipt from the medical provider;
and **REVERSED IN PART** with respect to Petitioner's request for a determination regarding eligibility for the [redacted] program.

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 review and process the Petitioner for eligibility for the [redacted].

2. The Department shall provide the Petitioner's AHR, Michele Lloyd, written notice of its determination for Petitioner's [redacted] eligibility.

LF/tm

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]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

cc: [redacted]

[redacted]