[redacted]

Date Mailed: March 15, 2018
MAHS Docket No.: 18-001234
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Amanda M. T. Marler

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 March 7, 2018, from Detroit, Michigan. The Petitioner was self-represented. The Department of Health and Human Services (Department) was represented by [redacted], Hearing Facilitator, [redacted], Eligibility Specialist, and [redacted], Assistance Payments Supervisor.

ISSUE

1. Did the Department properly reduce Petitioner's Food Assistance Program (FAP) benefits effective February 1, 2018?

2. Did the Department properly close Petitioner's Medical Assistance (MA) program benefits effective October 31, 2017?

3. Did the Department properly restart Petitioner's Medical Assistance (MA) program benefits?

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 is an ongoing FAP recipient.

2. Petitioner was an ongoing Medicaid Ad-Care program and Qualified Medicare Beneficiary recipient until November 1, 2017.

3. On September 5, 2017, the Department issued a Redetermination for Petitioner's MA programs due back to the Department by October 5, 2017.

4. Petitioner did not return the Redetermination to the Department.

5. On October 19, 2017, the Department issued a Health Care Coverage Determination Notice (HCCDN) advising Petitioner that her MA coverage was ending as of November 1, 2017, because she failed to return the Redetermination to the Department.

6. On October 30, 2017, Petitioner was at the local Department office completing a Mid-Certification Contact for her FAP benefits; the Department's computers were malfunctioning that day, and the case workers did not realize that Petitioner still had an outstanding Redetermination from earlier in the month.

7. After Petitioner left, the Department realized the need for the Redetermination, called the Petitioner and told her to come back, otherwise her MA coverage would end; ultimately, the Petitioner could not return to the Department office.

8. On November 1, 2017, Petitioner submitted a new application for MA coverage.

9. On November 1, 2017, the Department issued a HCCDN approving Petitioner for Medicaid (Ad-care) coverage effective November 1, 2017, and Medicare Savings Program (MSP) Qualified Medicare Beneficiary (QMB) coverage effective December 1, 2017, but denying Petitioner MSP coverage for November 2017.

10. The Department paid Petitioner's QMB coverage for January 2018, but not December 2017.

11. On January 10, 2018, the Department issued a Notice of Case Action reducing Petitioner's FAP benefits to $[redacted] effective February 1, 2018, as a result of the removal of a medical expense deduction.

12. On January 19, 2018, Petitioner submitted a hearing request disputing her MA coverage for November 2017 and reduction in FAP benefits beginning February 2018.

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).

Food Assistance Program

The Food Assistance Program (FAP) [formerly known as the Food Stamp program] is established by the Food and Nutrition Act of 2008, as amended, 7 USC 2011 to 2036a and is implemented by the federal regulations contained in 7 CFR 273. The Department (formerly known as the Department of Human Services) administers FAP pursuant to MCL 400.10, the Social Welfare Act, MCL 400.1-.119b, and Mich Admin Code, R 400.3001-.3011.

The Department reduced Petitioner's FAP benefits effective February 1, 2018, to $[redacted] after removal of the medical expense deduction. The medical expense deduction was removed because the Department began paying Petitioner's Medicare Premium through the Medicare Savings Program (MSP), more specifically, the QMB category. During the hearing, the Department presented FAP calculation budgets for both January 2018 and February 2018 to enable comparison of the changes.

In calculating a FAP budget, all countable earned and unearned income available to the client must be considered in determining a client's eligibility for program benefits and group composition policies specify whose income is countable. BEM 500 (July 2017), pp. 1-5. The Department determines a client's eligibility for program benefits based on the client's actual income and/or prospective income. Prospective income is income not yet received but expected. BEM 505 (October 2017), p. 1. In prospecting income, the Department is required to use income from the past 30 days if it appears to accurately reflect what is expected to be received in the benefit month, discarding any pay if it is unusual and does not reflect the normal, expected pay amounts. BEM 505, pp. 5-7. A standard monthly amount must be determined for each income source used in the budget. BEM 505, pp. 8-9. Income received twice per month is added together. BEM 505, p. 8. Income received biweekly is converted to a standard amount by multiplying the average of the biweekly pay amounts by the 2.15 multiplier. *Id*. Income received weekly is converted to a standard amount by multiplying the average of the weekly pay amounts by the 4.3 multiplier. BEM 505, pp. 7-9.

A review of the State Online Query (SOLQ) verifies Petitioner's unearned income of $[redacted] as properly budgeted by the Department. No evidence was presented of any other form of income. In addition, Petitioner did not list any other form of income on her MA application from October 2017.

After consideration of income, deductions are applied to achieve the net income. The deductions to income on the net income budget were also reviewed. There was evidence presented that the Petitioner's is a senior; therefore, the Senior, Disabled, or Disabled Veterans rules apply. BEM 550. The Petitioner is eligible for the following deductions to income:

- Dependent care expense.
- Excess shelter.
- Court ordered child support and arrearages paid to non-household members.
- Standard deduction based on group size.

- Medical deduction.
- An earned income deduction equal to 20% of any earned income.

BEM 554 (August 2017), p. 1; BEM 556 (July 2013), p. 3.

Neither party presented any evidence of a dependent care expense, child support expense, or earned income. Each of these items was appropriately listed on the FAP budgets calculation is listed as $0.00. The Department properly applied the Standard Deduction of $[redacted] In January 2018, the Department also properly applied the Medical Deduction for Petitioner's Medicare premium. In February 2018, the Department properly removed the Medical Deduction because the Department began paying the premium on Petitioner's behalf through the QMB category of MSP. Petitioner provided no proof of other medical expenses previously submitted to the Department. Finally, the Department properly applied the Excess Shelter Deduction after consideration of Petitioner's housing expense and heat and utility standard.

After a review of the January and February 2018 FAP budgets, the Department properly calculated Petitioner's Net Income and FAP benefit rate. RFT 260 (October 2017), pp. 6, 8. The Department acted in accordance with policy in calculating Petitioner's January 2018 FAP benefit rate and reducing Petitioner's February 2018 FAP benefit rate.

Medical Assistance

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, Petitioner was issued a Redetermination on September 5, 2017, due back to the Department by October 5, 2017. She did not return the document; and the Department issued an October 19, 2017, HCCDN notifying Petitioner that her MA coverage would end as of November 1, 2017. By happenstance, Petitioner was in the Department office after issuance of the HCCDN completing necessary paperwork for another program. Due to unforeseen circumstances, the Department's computer system was not functioning properly The Department worker did not become aware of the imminent closure of Petitioner's case until after she left the facility. Petitioner was not able to return that day and returned two days later with a completed MA application. As a result of the new application, Petitioner's Medicaid Ad-care coverage did not lapse. However, Petitioner's MSP QMB category coverage lapsed for a period of one month, November 2017. The Department states that the lapse in coverage was created by policy which requires the implementation of MSP coverage the month after an MA application is received.

The Department must periodically redetermine or renew an individual's eligibility for active programs. BAM 210 (January 2018), p. 1. With Medicaid programs, the redetermination is an eligibility review based upon a reported change. *Id.* Benefits stop at the end of the benefit period unless a renewal is completed and a new benefit period is certified. BAM 210, p. 4. If a client does not begin the redetermination process, the benefit period is allowed to expire. *Id*. The redetermination process begins when the client files an assistance application, redetermination, filing form, or food assistance benefits redetermination filing record. *Id*. In order to receive uninterrupted benefits, the client must file the completed redetermination by the 15th of the redetermination month. BAM 210, p. 15. If a client files an application for redetermination before the end of the benefit period, but fails to take a required action, the case is denied at the end of the benefit period. BAM 210, p. 20.

The Department issued the Redetermination, provided Petitioner with a month to return the form, then waited an additional two weeks before issuing the HCCDN, and then did not end Petitioner's MA coverage until November 1, 2017. Petitioner had adequate time to respond. While it would have been helpful if the Department's computers were fully functional on October 30, 2017, so that the Department would have been aware of the outstanding issue, the ultimate responsibility is on Petitioner to check her mail regularly and respond to Department requests for information. Therefore, the Department properly closed Petitioner's MA coverage as of November 1, 2017.

Once Petitioner submitted her new application for MA coverage, the Department again took appropriate action in starting coverage for her Medicaid Ad-Care program as of November 1, 2017. The only issue remaining is when the Department should have begun MSP coverage for Petitioner as a result of her November 1, 2017, application.

MSP is a State administered program in which the State pays an income eligible client's Medicare premiums, coinsurance, and deductibles. BEM 165, (January 2018), p. 2; BAM 810 (January 2018), p. 6. There are three MSP categories: (1) Qualified Medicare Beneficiaries (QMB), which pays for a client's Medicare premiums (both Part A, if any, and Part B), Medicare coinsurances and Medicare deductibles; (2) Specified Low-Income Medicare Beneficiaries (SLMB), which pays for a client's Medicare Part B premiums; and (3) Additional Low Income Medicare Beneficiaries (ALMB), which pays for a client's Medicare Part B premiums when funding is available. BEM 165, pp. 1-2. The MSP category a client is eligible for is dependent on the client's income. BAM 810, p. 6; BEM 165 (January 2018), p. 1. A client income-eligible for full coverage MA under the AD-Care program is also income-eligible for MSP under the QMB program. RFT 242 (April 2017), p. 1.

Department policy provides that the Department must do a MSP determination for individuals who are entitled to Medicare Part A and who are recipients of (i) MSP only, (ii) Group 2 Medicaid (both FIP-related and SSI-related), (iii) Extended Care Medicaid, or (iv) Healthy Kids Medicaid. BEM 165, pp. 2-3. In those cases, QMB coverage begins the calendar month after the processing month (the month during which an eligibility determination is made). BEM 165, pp. 3-4. However, individuals who are

entitled to Medicare Part A and who receive Medicaid under the AD-Care program are considered QMB eligible without a separate QMB determination. BEM 165, p. 3. QMB is not available for past months or the processing month. *Id*. For purposes of the QMB program, entitled to Medicare Part A means the person either (i) receives Medicare Part A with no premium being charged (as shown on the State Online Query (SOLQ), or (ii) refused premium-free Medicare Part A (indicated by a claim number suffix of M1), or (iii) is eligible for, or receiving, Premium HI (hospital insurance) (indicated by claim number suffix "M"). BEM 165, p. 5.

The parties agree that Petitioner was eligible for and received Ad-Care coverage before and after November 1, 2017. The parties further agree that Petitioner was a QMB recipient before November 1, 2017. Finally, the State Online Query shows that Petitioner was a recipient of Medicare Part A coverage with no premium. Since Petitioner was eligible for full coverage Ad-Care on November 1, 2017, no other MSP determination was necessary, and she is automatically eligible for QMB. If a determination had been necessary, QMB coverage would not be available for the past month or the processing month.

Finally, pursuant to policy, the Part B Buy-In program is used for paying the Part B premiums of QMB individuals and others, and provides that Part B Buy-In effective dates are determined by:

- The Social Security Administration for Supplemental Security Income recipients.
- The month QMB or SLMB coverage begins if the only basis for buy-in is MSP eligibility.
- Determined by DCH for ALMB.
- The earliest date that the client is both MA and Medicare Part B eligible for all other persons covered by the Buy-In Program, except that buy-in under Group 2 MA is not retroactive more than two years.

BAM 810, p. 8. In this case, Petitioner was Ad-Care eligible and Medicare Part B eligible on November 1, 2017. The parties also agree that she is eligible for QMB coverage. Since Petitioner was Ad-Care and Medicare Part B eligible and because Petitioner was being enrolled in the QMB program, the effective date of her QMB benefit should be November 1, 2017, not December 1, 2017. BEM 165, p. 3; BAM 810, p. 8. The Department erred in delaying Petitioner's QMB coverage until December 1, 2017.

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 calculated Petitioner's FAP benefit rate for January 2018 ongoing. The Department did not act in accordance with Department policy when it delayed the effectiveness date of Petitioner's MSP QMB coverage until December 1, 2017.

DECISION AND ORDER

Accordingly, the Department's decision is **AFFIRMED IN PART** with respect to the calculation of FAP benefits and **REVERSED IN PART** with respect to the implementation of Petitioner's MSP QMB coverage.

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 MSP coverage with an effectiveness date of November 1, 2017;

2. If Petitioner is otherwise eligible for MSP coverage effective November 1, 2017, issue supplements on Petitioner's behalf for benefits previously not issued; and

3. Notify Petitioner in writing of its decision.

Amanda M T Marler

AM/

Amanda M. T. Marler
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]