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Date Mailed: September 9, 2019
MOAHR Docket No.: 19-008405
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 4, 2019, from [redacted] Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Catrice Legacy, Eligibility Specialist and Lisa Carter, Eligibility Specialist.

ISSUE

Did the Department properly remove medical expenses from Petitioner's Food Assistance Program benefits (FAP) benefits and properly reduce the FAP 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. The Petitioner is an ongoing recipient of FAP benefits from the Department.

2. The Petitioenr's FAP group consists of two members, and Petitioner is disabled. The Petitioner pays rent of $1,000.00 a month and pays for heat and electricity.

3. Pursuant to a Department-wide review, the Petitioner's ongoing medical deductions used to calculate his FAP benefits were reviewed, and the Department removed medical expenses which it determined were not ongoing. The Department had been including the expenses since 2016. The Department continued to include the Petitioner's Medicare Part B premium for $135.50 and his private health insurance premium of $223.73 for a total of $359.73 and then

applied the $35.00 disregard leaving an ongoing medical expense of $324.00 a month.

4. Prior to the Department's review, the Department was including $715.00 of monthly ongoing medical expenses when calculating the Petitioner's FAP benefits. Exhibit B.

5. The Petitioner receives Retirement, Survivors and Disability Insurance (RSDI) from the Social Security Administration of $2,082.00. The Petitioner's wife also receives $144.00 monthly.

6. The Department sent a Notice of Case Action dated July 23, 2019, notifying the Petitioner that his FAP benefits had been reduced to $95.00, effective September 1, 2019. Exhibit E.

7. The only change made to the Petitioner's FAP budget was the reduction of medical expenses.

8. The Petitioner requested a timely hearing on July 29, 2019, protesting the reduction of his FAP benefits.

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 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.

In this case, the Department reviewed the Petitioner's FAP budget ongoing medical expenses and determined that some of the expenses were not ongoing. The Department did not speak to the Petitioner about any of the expenses before removing some of the medical expenses it determined were not ongoing. The Department redetermined the ongoing medical expenses and included the Medicare Part B premium of $135.50 and a health insurance premium in the amount of $223.73. The new ongoing medical deduction for ongoing expenses was $359.23 before the $35.00 deduction was made. Exhibits A, p. 3; and Exhibit C, p. 26. The individual who made the decision to remove some of the medical expenses was not present at the hearing to explain the reason for the removal of the other expenses and what other information was considered. The Department had been previously deducting a total of $715.00 in

ongoing medical expenses since 2016, prior to the 2019 current review. The FAP medical expense review conducted in this case was based upon a local office review of all FAP budgets containing medical expenses. There was no evidence that it was due to a redetermination or a review during the ongoing benefit period due to a reported change. No verification of any of the medical expenses removed by the Department were requested from the Petitioner, the removals were unilateral.

Medical expenses can be budgeted as one-time expenses or as ongoing expenses depending on the individual's circumstance and the type of expense. BEM 554 (August 2017), pp. 8-12. For groups with one or more SDV members, Bridges allows medical expenses for the SDV member(s) that exceed $35.00. As the Petitioner is disabled, he is an SDV group member; and his medical expenses are allowed. The Department must complete either a manually calculated or Bridges budget to document expenses every time an expense change is reported.

When budgeting medical expenses, the Department is required to :

Consider **only** the medical expenses of SDV persons in the eligible group or SDV persons disqualified for certain reasons; Estimate an SDV person's medical expenses for the benefit period. Base the estimate on all of the following:

- Verified allowable medical expenses.
- Available information about the SDV member's medical condition and health insurance.
- Changes that can reasonably be anticipated to occur during the benefit period. BEM 554 (October 2019), pp. 8-9.

During the Benefit Period

A FAP group is not required to, but may voluntarily report changes during the benefit period. Process changes during the benefit period **only** if they are one of the following:

- Voluntarily reported and verified during the benefit period such as expenses reported and verified for MA deductible.
- Reported by another source and there is sufficient information and verification to determine the allowable amount without contacting the FAP group.

One-Time-Only Expenses

Groups that do not have a 24-month benefit period may choose to budget a one-time-only medical expense for one month or average it over the balance of the benefit period. Bridges will allow the expense in the first benefit month the change can affect.

Exception: Groups that have 24-month benefit periods must be given the following options for one-time-only medical expenses billed or due within the first 12 months of the benefit period:

1. Budget it for one month.

2. Average it over the remainder of the first 12 months of the benefit period.

3. Average it over the remainder of the 24-month benefit period.

In this case, the evidence presented at the hearing by the Department indicates that the Department removed the following expenses based on the Medical Expenses Summary provided at the hearing: $79.00 outpatient treatment reported May 16, 2019; $12.42 prescription drugs reported June 17, 2019; $38.68 medical dental and vision including transportation reported January 18, 2019; $223.73 medical/dental vision services including transportation; $31.49, prescription drugs reported October 12, 2018; $29.18, prescriptions drugs reported October 12, 2018; $9.50 prescription drugs reported on October 12, 2018; and $7.49, prescription drugs reported on October 11, 2018; and $122.86 health hospitalization reported June 10, 2015. Exhibit A, pp. 18-19. These expenses total $554.35. The removed expense shown above for $223.73 for medical/dental/vision services appears to be a duplicate expense amount as the same expense appears earlier in the summary and is reported for the same date as a health insurance premium. Exhibit A.

The Department allowed two on the medical expense summary: $135.50 (Medicare Part B Premium) and $223.73 (Blue Cross Premium). These expenses total $359.73.

Although it is important to update medical expenses and is required by the Department at redetermination and application as well as when a change is reported, here, the Department did not explain how it verified or determined that a medical expense reported by Petitioner was or was not ongoing or a one-time expense.

A FAP group is not required to but may voluntarily report changes during the benefit period. Reported changes during the benefit period are to be processed **only** if they are one of the following:

- Voluntarily reported and verified during the benefit period such as expenses reported and verified for MA deductible.

- Reported by another source and there is sufficient information and verification to determine the allowable amount without contacting the FAP group. BEM 554, p. 9.

The department is directed to estimate an SDV recipient's medical expenses for the benefit period. The expense does **not** have to be paid to be allowed. Allow medical expenses when verification of the portion paid, or to be paid by insurance, Medicare, Medicaid, etc. is provided. Allow **only** the non-reimbursable portion of a medical expense. The medical bill cannot be overdue. BEM 554. p. 11.

The Department must verify allowable medical expenses including the **amount of reimbursement,** at initial application and redetermination. Verify reported changes in the source or amount of medical expenses if the change would result in an increase in benefits.

> Do not verify other factors, unless questionable. Other factors include things like the allowability of the service or the eligibility of the person incurring the cost. BEM 554, p. 12.

Acceptable verification sources include, but are not limited to:

- Current bills or written statement from the provider, which show all amounts paid by, or to be paid by, insurance, Medicare or Medicaid.
- Insurance, Medicare or Medicaid statements which show charges incurred and the amount paid, or to be paid, by the insurer.
- DHS-54A, Medical Needs, completed by a licensed health care professional.
- SOLQ for Medicare premiums.
- Written statements from licensed health care professionals.

Collateral contact with the provider. (Most commonly used to determine cost of dog food, over-the-counter medication and health-related supplies, and ongoing medical transportation). Acceptable verification sources include, but are not limited to:

- Current bills or written statement from the provider, which show all amounts paid by, or to be paid by, insurance, Medicare or Medicaid.
- Insurance, Medicare or Medicaid statements which show charges incurred and the amount paid, or to be paid, by the insurer.
- DHS-54A, Medical Needs, completed by a licensed health care professional.
- SOLQ for Medicare premiums.
- Written statements from licensed health care professionals.
- Collateral contact with the provider. (Most commonly used to determine cost of dog food, over-the-counter medication and health-related supplies, and ongoing medical transportation). BEM 554, p. 12.

After a thorough review of this matter, it is determined that the Department was required to verify medical expenses that it was removing if the expense was questionable. Looking at the Medical Expense Summary, it is determined that the Department presented no evidence to support the removal of prescription drug expenses without prior verification. Likewise, other expenses such as medical, dental and vision services

needed to be verified to determine if they were one-time expenses or ongoing. The only expenses that were properly removed were the health premium hospitalization insurance premium reported in June of 2015 in the amount of $122.86. Another questionable expense that should have been verified as it was only reported in January 2019 and appears to be a duplicate expense, is the double entry of $223.73 for health insurance premium and again as a dental/vision expense.

Because the Department did not explain the basis for the removal of the other expenses, the Department did not meet its burden of proof to demonstrate that the remaining expenses were properly removed and not ongoing particularly because they were for the most part prescription drugs and services. The Department must recalculate and request verification of all ongoing medical expenses and determine if any of the expenses reported are for services that were incurred in one month and spread over the remainder of the benefit period. It should also be noted that the Petitioner also attached to his hearing request copies of his ongoing prescriptions several of which appear on the list of removed expenses.

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 did not act in accordance with Department policy when it recalculated Petitioner's FAP benefits and removed medical expenses and in doing so failed to satisfy its burden of showing that it acted in accordance with Department policy in BEM 554.

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. The Department shall recalculate the Petitioner's FAP benefits as regards the correct ongoing medical expense and shall include and remove medical expenses shown on the Medical Expense Report as well as seek verification from Petitioner of all ongoing medical expenses presently incurred.

2. The Department shall issue a FAP supplement to Petitioner only if appropriate in accordance with Department policy.

3. The Department shall provide written notice to the Petitioner of its medical expense determination and correct FAP benefit amount.

LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS (via electronic mail)

Linda Gooden
MDHHS-Oakland-6303-Hearings
BSC4
M Holden
D Sweeney

Petitioner (via first class mail)

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