Michigan Office of Administrative Hearings and Rules
P.O. Box 30639
Lansing, MI 48909

Date Mailed: April 24, 2025
Docket No.: 25-011770
Case No.: [redacted]
Petitioner: [redacted] [redacted]

[redacted]

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

HEARING DECISION

On March 24, 2025, Petitioner [redacted] [redacted] requested a hearing to dispute public assistance benefits. As a result, a hearing was scheduled to be held on April 22, 2025. Public assistance hearings are held 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; 45 CFR 205.10; and Mich Admin Code, R 792.11002.

The parties appeared for the scheduled hearing. Petitioner appeared and represented herself. Respondent Michigan Department of Health and Human Services (Department) had Assistance Payments Supervisor Amanda Boobyer appear as its representative. Neither party had any additional witnesses.

Both parties provided sworn testimony, and one exhibit was admitted into evidence. A 44-page packet of documents provided by the Department was admitted into evidence collectively as Exhibit A.

ISSUES

Did the Department properly determine Petitioner's Food Assistance Program (FAP) benefit amount?

Did the Department properly determine Petitioner's Medicaid eligibility?

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 a resident of [redacted] County.

2. Petitioner is a senior or disabled individual.

3. Petitioner is not married.

4. Petitioner receives a gross benefit of $[redacted] per month from Social Security RSDI.

5. Petitioner pays a housing cost of $[redacted] per month, which consists of her property taxes.

6. Petitioner is responsible for paying for heating/cooling utilities for her home.

7. Petitioner does not pay any health insurance premiums.

8. Petitioner does not pay for any remedial services.

9. On February [redacted] 2025, Petitioner provided two medical bills to the Department. One medical bill was from [redacted] for account XXX8007 with a total amount due of $[redacted] and one medical bill was from [redacted] for account XXXX5871 with a total amount due of $[redacted] These bills were incurred from a hospital stay.

10. The Department processed Petitioner's medical bills and redetermined her FAP benefit amount. The Department determined that Petitioner's medical bills were one-time only expenses, and the Department budgeted a medical expense for Petitioner's medical bills for one month.

11. On February [redacted] 2025, the Department mailed a notice of case action to Petitioner to notify her that her FAP benefit increased to $[redacted] per month, effective March 1, 2025. The notice of case action did not state that the increase was only effective for one month; the notice of case action stated that Petitioner was approved for a FAP benefit of $[redacted] per month from March 1, 2025, through October 31, 2026.

12. On March [redacted] 2025, Petitioner submitted a redetermination to the Department to renew her Medicaid eligibility.

13. On March [redacted] 2025, the Department mailed a notice of case action to Petitioner to notify her that her FAP benefit decreased to $[redacted] per month, effective April 1, 2025. The notice of case action stated that Petitioner was approved for a FAP benefit of $[redacted] per month from April 1, 2025, through October 31, 2026. The

notice of case action stated that Petitioner's FAP benefit amount was based on the following:

a. Group size of one.

b. Unearned income of $[redacted] per month.

c. Standard deduction of $[redacted] per month.

d. Housing cost of $[redacted] per month.

e. Heat/utility standard of $[redacted] per month.

14. The Department redetermined Petitioner's Medicaid eligibility, and the Department determined that the best Medicaid coverage Petitioner was eligible for was Medicaid with a $[redacted] monthly deductible and Medicare Savings Program coverage.

15. On March [redacted] 2025, the Department mailed a benefit notice to Petitioner to notify her that she was eligible for Medicaid with a $[redacted] monthly deductible, effective April 1, 2025. The notice also notified Petitioner that she was eligible for Medicare Savings Program coverage, effective April 1, 2025.

16. Petitioner requested a hearing to dispute her FAP benefit amount and her Medicaid eligibility.

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

The Food Assistance Program (FAP) 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 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 did not properly budget a medical expense for Petitioner's medical bills. FAP groups may choose to budget a one-time only medical expense for one month or average it over the benefit period. BEM 554 (January 1, 2025), p. 10. For FAP groups with a 24-month benefit period, the client may choose to budget the medical expense for one month, average it over the remainder of the first 12 months, or average it over the remainder of the 24-month benefit period. *Id.* The Department should process a client's medical expense in the way that is most advantageous to the client. In this case,

Petitioner incurred one-time only medical expenses totaling $[redacted] and Petitioner provided sufficient proof of these medical expenses to the Department as verification. Petitioner provided proof of her medical expenses to the Department in February 2025, and Petitioner's benefit period ran through October 31, 2026. Thus, Petitioner had the option to budget her medical expense for one month, average it over the remainder of the first 12 months (through October 31, 2025), or average it over the remainder of the 24-month benefit period (through October 31, 2026).

Petitioner would realize the greatest immediate benefit if she chose to budget her medical expense for one month because Petitioner would receive the maximum FAP benefit amount of $[redacted] for one month. However, Petitioner would realize the greatest total benefit if she chose to average her medical expense over the remainder of the first 12 months (through October 31, 2025) because Petitioner would receive a FAP benefit of approximately $[redacted] per month through October 2025. Petitioner would not receive any benefit if she chose to average her medical expense over the remainder of her 24-month benefit period. The Department should have given Petitioner the opportunity to decide how she wanted the Department to budget her medical expense, and the Department did not, so the Department did not properly budget Petitioner's medical expense.

For these reasons, the Department's FAP benefit determination is reversed. The Department must reprocess Petitioner's medical expense. The Department must give Petitioner the option to have her medical expense budgeted for one month to get the greatest immediate benefit or to have it averaged over the remainder of the first 12 months of her benefit period for the greatest total benefit, and the Department must process the total medical expense of $[redacted] in accordance with Petitioner's choice.

MEDICAID

Medicaid is known as Medical Assistance (MA). The 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 administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Full-coverage Medicaid is available to eligible individuals through the AD Care program. In order for a client to be eligible for full-coverage Medicaid through the AD Care program, the client must be aged or disabled, and the client's group's net income must not exceed 100% of the Federal Poverty Level (FPL). BEM 163 (July 1, 2017), pp. 1-2. For AD Care, the client's group size consists of the client and the client's spouse. BEM 211 (October 1, 2023), p. 8. In this case, Petitioner's group size consists of one because Petitioner does not have a spouse. The FPL for a group size of one in 2025 is $15,060.00. 90 FR 5917 (January 17, 2025). The applicable FPL is equal to a monthly income of $1,255.00.

When group members receive income from Social Security RSDI, the gross amount received from RSDI is countable. BEM 163 at 2. However, $20.00 is disregarded from unearned income such as Social Security RSDI income. BEM 541 (January 1, 2025), p. 3. In this case, Petitioner received $[redacted] per month from Social Security RSDI. After the $20.00 disregard, the countable amount of her Social Security RSDI was $[redacted] per month. Petitioner's countable Social Security RSDI was over the income limit for full-coverage Medicaid through the AD Care program, so the Department properly determined that Petitioner was ineligible for full-coverage Medicaid through the AD Care program.

Since the Department determined that Petitioner was ineligible for full-coverage Medicaid through the AD Care program, the Department properly determined that the best Medicaid coverage that she was eligible for was Medicaid with a monthly deductible. Medicaid with a monthly deductible is known as Group 2 Medicaid. Group 2 Medicaid is available to clients who are aged or disabled and ineligible for full-coverage Medicaid through the AD Care program. BEM 166 (April 1, 2017), p. 1. Group 2 Medicaid eligibility is determined on a monthly basis. In general, Group 2 Medicaid provides coverage from the date a client met her deductible through the end of the month.

A client's deductible is determined by calculating the client's net income and then subtracting the client's needs as defined by BEM 544. *Id.* at 2. Thus, the first step is determining a client's net income. A client's net income is a client's countable income as defined by policy. BEM 530 (April 1, 2020), p. 2. In this case, Petitioner's countable income is $[redacted] as discussed above.

The next step is determining a client's needs as defined by BEM 544. A client's needs as defined by BEM 544 consists of: (1) a protected income level set by policy, (2) the cost of health insurance premiums, and (3) the cost of remedial services. BEM 544 (January 1, 2020), pp. 1-2. The applicable protected income limit for [redacted] County is only $375.00 per month for a single individual. RFT 200 (April 1, 2017) and RFT 240 (December 1, 2013). Petitioner did not pay any health insurance premiums or costs of remedial care, so Petitioner's needs are limited to the $375.00 protected income limit.

The Department properly determined Petitioner's deductible when the Department determined that Petitioner's monthly deductible was $[redacted] Petitioner's net income was $[redacted] and her needs as defined by BEM 544 were $375.00. Petitioner's net income of $[redacted] minus her needs of $375.00 equals her monthly deductible of $[redacted]

The Department also determined that Petitioner was eligible for Medicare Savings Program coverage. Medicare Savings Program coverage is a type of Medicaid that helps pay costs that are not covered by Medicare. There are three basic types of Medicare Savings Program coverage: QMB, SLMB, and ALMB. BEM 165 (July 1, 2024), p. 1. QMB pays for Medicare premiums, Medicare coinsurances, and Medicare deductibles. *Id.* at 2. SLMB only pays Medicare Part B premiums. *Id.* ALMB only pays Medicare Part B

premiums if there is sufficient funding available. *Id.* Thus, QMB is the best coverage, SLMB is the next best coverage, and ALMB is the lowest level of coverage.

The type of Medicare Savings Program coverage a client is eligible for is determined based on income. The income limit for QMB is the same as for full-coverage Medicaid through the AD Care program. *Id.* at 1. The income limit for SLMB is 120% of the FPL. *Id.* The income limit for ALMB is 135% of the FPL. Petitioner's countable income of $[redacted] per month was 114% of the FPL. Thus, the Department properly determined that Petitioner was eligible for Medicare Savings Program coverage.

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 the Department acted in accordance with its policies and the applicable law when it determined Petitioner's Medicaid eligibility, and the Department did not act in accordance with its policies and the applicable law when it determined Petitioner's FAP benefit amount.

IT IS ORDERED that the Department's decision is **AFFIRMED IN PART and REVERSED IN PART**. The Department's Medicaid eligibility decision is affirmed, and the Department's FAP benefit amount decision is reversed. The Department must reprocess Petitioner's medical expense to determine Petitioner's FAP benefit amount. In doing so, the Department must use a medical expense of $[redacted] the Department must give Petitioner the option to have her medical expense budgeted for one month to get the greatest immediate benefit or to have it averaged over the remainder of the first 12 months of her benefit period for the greatest total benefit, and the Department must process the medical expense of $[redacted] in accordance with Petitioner's choice. The Department must begin to implement this order within 10 days of the mailing date of this hearing decision.

JEFFREY KEMM
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via Electronic Mail:

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Via First Class Mail:

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