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

Date Mailed: January 16, 2026
Docket No.: 25-040553
Case No.: [redacted]
Petitioner: [redacted]

[redacted] MI [redacted]

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

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这是一份重要的法律文件。请让别人翻译文件。

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

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HEARING DECISION

On October 29, 2025, Petitioner [redacted] requested a hearing to dispute a Medicaid determination. As a result, a hearing was scheduled to be held on January 13, 2026. 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 with his witness, [redacted]. Respondent Michigan Department of Health and Human Services (Department) had Assistance Payments Supervisor Jarrod Swartz appear as its representative. There were no other participants.

Both parties provided sworn testimony, and one exhibit was admitted into evidence. A 43-page packet of documents provided by the Department was admitted collectively as Exhibit A.

ISSUE

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 not married.
2. Petitioner is a resident of [redacted].
3. Petitioner's birth date is [redacted] 1958.
4. Petitioner is qualified for Medicare coverage.
5. Petitioner does not pay any health insurance premiums, and Petitioner does not pay for any remedial services.
6. Petitioner received a gross monthly benefit of $[redacted] from Social Security RSDI in 2025.
7. Petitioner had full-coverage Medicaid through the Healthy Michigan Plan.

8. The Department redetermined Petitioner's Medicaid eligibility, and the Department determined that the best Medicaid coverage that Petitioner was eligible for was Medicaid with a $1,728.00 monthly deductible and limited-coverage Medicaid through Plan First.

9. On October 17, 2025, the Department mailed a health care coverage determination notice to Petitioner to notify him that he was eligible for Medicaid with a $1,728.00 monthly deductible, effective November 1, 2025. The Department also notified Petitioner that he was eligible for limited-coverage Medicaid through Plan First, effective November 1, 2025.

10. Petitioner requested a hearing to dispute his Medicaid eligibility. Petitioner is disputing his Medicaid coverage because he would like full-coverage Medicaid.

11. The Department reinstated Petitioner's full-coverage Medicaid through the Healthy Michigan Plan while his hearing request was pending.

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).

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.

In this case, Petitioner requested a hearing to dispute his Medicaid coverage because the Department changed Petitioner's Medicaid from full-coverage Medicaid through the Healthy Michigan Plan to Medicaid with a monthly deductible. Petitioner wants full-coverage Medicaid. The issue is whether the Department properly determined that the best Medicaid coverage that Petitioner was eligible for was Medicaid with a monthly deductible.

Full-coverage Medicaid is available to eligible individuals through the Healthy Michigan Plan. In order for a client to be eligible for full-coverage Medicaid through the Healthy Michigan Plan, the client must be aged 19 to 64 years old, and the client must not be qualified for Medicare coverage. BEM 137 (January 1, 2024), p. 1. Petitioner was not aged 19 to 64 years old, and Petitioner was qualified for Medicare coverage, so Petitioner was ineligible for full-coverage Medicaid through the Healthy Michigan Plan.

Thus, the Department properly determined that Petitioner was ineligible for full-coverage Medicaid through the Healthy Michigan Plan.

Full-coverage Medicaid is also 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 consisted of one because Petitioner did not have a spouse. The FPL for a group size of one in 2025 was $15,650.00. 90 FR 5917 (January 17, 2025). The applicable FPL was equal to a monthly income of $1,304.17.

When group members receive income from Social Security RSDI, the gross amount received from Social Security 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 was receiving $[redacted] per month from Social Security RSDI. After the $20.00 disregard, the countable amount of his Social Security RSDI was $[redacted] per month. Petitioner's countable income exceeded the applicable 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 he 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 his 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 was $[redacted].

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 Kent County was only $391.00 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 were limited to the $391.00 protected income limit.

Petitioner's deductible was $[redacted] per month because Petitioner's net income of $[redacted] minus his needs of $391.00 equaled his monthly deductible. The Department properly determined Petitioner's deductible when the Department determined that Petitioner's monthly deductible was $[redacted].

The Department also determined that Petitioner was ineligible 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 163% of the FPL. Thus, the Department properly determined that Petitioner was ineligible for any Medicare Savings Program coverage.

Lastly, the Department found Petitioner eligible for limited-coverage Medicaid through Plan First. Coverage through Plan First is limited because it only covers family planning services. The income limit for limited-coverage Medicaid through Plan First is 195% of the FPL. BEM 124 (July 1, 2023), p. 1. Petitioner's income was less than the income limit, so the Department properly found Petitioner eligible for limited-coverage Medicaid through Plan First.

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.

IT IS ORDERED: the Department's decision is **AFFIRMED.**

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: **Respondent**
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Via First Class Mail: **Petitioner**
[redacted]
MI [redacted]