STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted],

Claimant

Reg. No: 2008-29500
Issue No: 2014
Case No: [redacted]
Load No:
Hearing Date:
May 13, 2009
Macomb County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a telephone hearing was held on May 13, 2009. Claimant personally appeared and testified.

ISSUE

Did the Department of Human Services (the department) properly determine that claimant was no longer eligible for Medical Assistance (MA) and institute a spend-down?

FINDINGS OF FACT

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

(1) Claimant was an ongoing Medical Assistance benefits recipient based upon Healthy Kids and Group 2 FIP related Medical Assistance.

(2) During the redetermination process, the department caseworker found claimant to have excess income for full coverage Medical Assistance.

(3) On July 21, 2008, the department caseworker sent claimant notice that her Medical Assistance benefits would be cancelled and a spend-down case would be opened with a spend-down amount of $70 per month effective August 1, 2008.

(4) On August 4, 2008, claimant filed a request for a hearing to contest the department's negative action.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

Michigan provides Medical Assistance for eligible clients under two general classifications: Group 1 and Group 2 MA. Claimant qualified under the Group 2 classification which consists of claimants whose eligibility results when the State designates certain types of individuals as medically needy. PEM, Item 105. In order to qualify for Group 2 MA, a medically needy client must have income that is equal to or less than the basic protected basic income level. It is not disputed that claimant qualifies for Medical Assistance based upon the fact that she is a caretaker relative of a minor child.

Department policy sets forth a method for determining the protective basic maintenance level by considering:

1. The protected income level.
2. The amount diverted to dependents.
3. Health insurance or premiums.
4. Remedial services if determining the eligibility for claimant's in adult care homes.

If a client's income exceeds the protected income level, the excess amount must be used to pay medical expenses before Group 2 MA coverage can begin. This process is known as a spend-down. The policy requires the department to count and budget all income received that it is not specifically excluded. There are three main types of income:

1. Countable earned,
2. Countable unearned, and
3. Excluded.

Earned income means income received from another person or organization or from self-employment for duties that were performed for remuneration or profit. Unearned income is any income that is not earned income. The amount of income counted may be more than the amount the person actually receives, because it is the amount before the deductions are taken including deductions for taxes and garnishments. The amount before any deductions are taken is called the gross amount. PEM, Item 500, p. 1. The department, in the instant case, calculated claimant's income based upon earned income in the amount of [redacted] for the month of July 2008.

After giving the claimant the appropriate unearned and earned income expense deductions, the claimant was receiving [redacted] per month in net monthly income. Claimant was given a work expense, a dependent care expense, as well as a prorated share which went to the minor child for support which left her with [redacted] in net monthly income. The Administrative Law

Judge has reviewed the record and exhibits and finds that the fiscal groups net income after being provided with the most beneficial earned income deductions is [redacted] per month.

Federal regulations at 42 CFR 435.831 provide standards for the determination of the MA monthly protected income levels. The department is in compliance with the Program Reference Manual, Tables, Charts and Schedules, Tables 240-1. Table 240-1 indicates that the claimant's monthly protected income level for the claimant's fiscal group of one person is [redacted] in total net income minus [redacted] in total needs which equals net monthly excess income in the amount of $70. The department's determination that claimant had excess income for purposes of Medical Assistance eligibility is correct.

Deductible spend-down is a process which allows a customer with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred. PEM, Item 545, p. 1. Meeting the spend-down means reporting and verifying allowable medical expenses that equal or exceed the spend-down amount for the calendar month tested. PEM, Item 545, p. 9. The group must report expenses by the last day of the third month following the month it wants MA coverage. PEM, Item 30 explains the verification of timeliness standards. PEM, Item 545, p. 9. In addition, in claimant's income changes as claimant does have fluctuated income because she works retail, claimant is under the obligation to notify the department when her income changes within 10 days of that change.

The department's determination that claimant had a spend-down amount of $70 per month is correct. (Exhibits 1-4)

Claimant's allegation that she does not have much money and that the spend-down is unfair because of her other expenses, is a compelling and equitable argument to excuse from the department's policy requirements.

The claimant's grievance centers on dissatisfaction with the department's current policy. The claimant's request is not within the scope of authority delegated to this Administrative Law Judge pursuant to a written directive signed by the Department of Human Services Director, which states:

> Administrative Law Judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations or overrule or make exceptions to the department policy set out in the program manuals.

Furthermore, administrative adjudication is an exercise of executive power rather than judicial power, and restricts the granting of equitable remedies. *Michigan Mutual Liability Co. v Baker*, 295 Mich 237; 294 NW 168 (1940).

The Administrative Law Judge has no equity powers. Therefore, the Administrative Law Judge finds that the department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant had excess income for purposes of Medical Assistance benefit eligibility and when it determined that claimant had a monthly deductible spend-down in the amount of $70.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department did appropriately determine that claimant had excess income for purposes of Medical Assistance benefit eligibility. The department also properly determined that claimant had a deductible spend-down of $70.

Accordingly, the department's decision is AFFIRMED.

/s/
Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: June 4, 2009

Date Mailed: June 5, 2009

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

LYL/vmc

cc: [redacted]