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: 2009-11836
Issue No: 2026
Case No: [redacted]
Load No: [redacted]
Hearing Date:
November 4, 2009
Macomb County DHS

ADMINISTRATIVE LAW JUDGE: Jonathan W. Owens

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 November 4, 2009. Claimant appeared and testified.

ISSUE

Did the Department properly determine the Claimant's MA coverage?

FINDINGS OF FACT

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

1. On December 11, 2008, the Department completed a MA budget for the Claimant. The Department determined, based on SSA amount, the Claimant qualified for MA. However, the Claimant's LTC coverage would have a Patient Pay Amount of $674.

2. On December 23, 2008, Claimant filed a request for hearing.

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 (formerly known as the Family Independence Agency) 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 MA for eligible clients under two general classifications: Group 1 and Group 2 MA. Claimant falls under Group 2 MA classification which consists of client's whose eligibility results from the state designating types of individuals as "medically needy." MCL 400.106; MSA 16.490 (16), MCL 400.107; MSA 16.490(17), and PEM, Item 105.

In order to qualify for Group 2 MA, a medically needy client must have income which is equal to or less than the protected basic maintenance level. Department policy sets forth the method for determining the protected basic maintenance level by considering: (1) the protected income level; (2) the amount diverted to dependents; (3) health insurance premiums; and (4) remedial services if determining eligibility for clients in adult-care homes. The protected income level is a set amount for non-medical needs such as shelter, food and incidental expenses. In all other cases other than those involving long-term care, the appropriate protected income level must be taken from PRT 240. PEM Item 545, and 42 CFR 435.811 through 435.814. If the individual'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 "spend-down." Policy requires the agency to count and budget all income received that is not

specifically excluded. There are three main types of income: countable earned, countable unearned and excluded.

PEM Item 545, p. 1

MA Only

This item completes the Group 2 MA income eligibility process.

Income eligibility exists for the calendar month tested when:

There is no excess income, **or**
Allowable medical expenses (defined in "EXHIBIT I") equal or exceed the excess income.

When **one** of the following equals or exceeds the group's excess income for the month tested, income eligibility exists **for the entire month**:

Old bills (defined in "EXHIBIT IB").

Personal care services in clients home, Adult Foster Care (AFC), or Home for the Aged (HA) (defined in "EXHIBIT II").

Hospitalization (defined in "EXHIBIT IC").

Long-term care (defined in "EXHIBIT IC").

When **one** of the above does **not** equal or exceed the group's excess income for the month tested, income eligibility begins either:

The exact day of the month the allowable expenses **exceed** the excess income, **or**

The day after the day of the month the allowable expenses **equal** the excess income.

In addition to income eligibility, the fiscal group must meet all other financial eligibility factors for the category processed. However, eligibility for MA coverage exists only for qualified fiscal group members. A qualified fiscal group member is an individual who meets all the nonfinancial eligibility factors for the category processed.

PEM Item 546, p. 1

PATIENT-PAY AMOUNT

The post-eligibility PPA is total income minus total need.

Total income is the client's countable unearned income plus his remaining earned income.

Total need is the sum of the following when allowed by later sections of this item:

- Patient Allowance
- Community Spouse Income Allowance.
- Family Allowance.
- Children's Allowance.
- Health Insurance Premiums.
- Guardianship/Conservator Expenses.

In the present case, Claimant's representative asserts the Claimant should either have no Patient Pay Amount (PPA) or in the alternative, the amount should be reduced. The Claimant was hospitalized on October 1 and remained in the hospital until October 5th at which time he went to a skilled nursing facility for rehab treatment. The Claimant's representative asserts the following:

1. The Claimant was in the hospital for 5 days prior to going to skilled rehab, and Medicare, according to the Claimant's representative, pays the first 20 days of care and the remaining days would be 80%. Therefore, the state should prorate the amount of the PPA in relation to this Medicare coverage along with the MA coverage.
2. The Claimant should be allowed to deduct the costs of his home expense as allowed by 42 CFR 435.725.

The Claimant's first assertion fails to be supported by policy or by law. This Administrative Law Judge could find no allowance for any such pro-ration of benefit based upon Medicare coverage. The policy clearly indicates a change occurs when an individual goes from a hospital into a long term care facility. There is no mention or allowance granted for what Medicare may or may not cover for an individuals care. Therefore, this assertion is not supported. See above policy cites.

The second assertion is the Claimant should be allowed to deduct his housing costs from his income. The Claimant is a single individual. The Departmental policy fails to provide such a deduction. However, 42 CFR 435.725(d) does provide an "optional deduction" for single individuals housing costs. The Department has not adopted this option and has not allowed single individuals to deduct those housing expenses. As indicated above the law provides for an "optional deduction" not a mandated or required deduction allowance.

> 42 CFR 435.725(d)
>
> (d) **Optional deduction**: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if--
>
> (1) The amount is deducted for not more than a 6-month period; and
>
> (2) A physician has certified that either of the individuals is likely to return to the home within that period.
>
> (3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—
>
> (i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

Based upon the above, this Administrative Law Judge finds the Department properly determined the amount of the PPA for the Claimant's case.

Incidentally, this Administrative Law Judge understands, while single individuals in LTC may not be allowed housing expenses, a client or authorized representative or advocacy group (working with the client) can contact Steve Fitton at Community Health and request a reduction in the clients PPA due to their housing expenses.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Department properly determined the Claimant's coverage.

Accordingly, the Department's decision is hereby AFFIRMED.

Jonathan W. Owens
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: 03/23/10

Date Mailed: 03/24/10

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.

JWO/dj

cc: [redacted]