STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 11F-03329

PETITIONER,

Vs.

CASE NO. 1296149307

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88326

RESPONDENT.
_____/

FILED
Sep 15, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 22, 2011, at 3:00 p.m.

APPEARANCES

For the Petitioner: [redacted], the petitioner's father

For the Respondent: [redacted], ACCESS supervisor.

ISSUE

The petitioner is appealing the respondent's action to determine the petitioner's patient responsibility to be $600.

PRELIMINARY STATEMENT

By notice dated August 5, 2010, the respondent informed the petitioner that his application was approved and his patient responsibility was $600. On May 16, 2011, the petitioner requested a hearing.

The respondent requested that the appeal be dismissed on the basis that the petitioner did not timely request a hearing. The hearing officer stated at the hearing that the response to the motion would be in the Final Order.

The petitioner's representative and the respondent's representative appeared in person. [redacted], ACCESS economic self-sufficiency specialist was observing.

FINDINGS OF FACT

1. The petitioner resides in a nursing facility. Applications were filed for the petitioner for Institutional Care Program and Medicaid Program benefits on October 21, 2008, June 17, 2009 and July 13, 2009.

2. The petitioner's father filed a recertification application for the petitioner on August 3, 2010 for the effective month of September 2010. The petitioner's father was indicated as the authorized/designated representative on the application. The petitioner's income is Social Security benefits in the amount of $635. The petitioner's father is the payee for the petitioner's Social Security benefits. The reapplication did not indicate any expenses.

3. The respondent reviewed the recertification application. The respondent determined that the patient responsibility would be the petitioner's income less a $35 personal needs allowance for an amount of $600. The case was authorized on August 4, 2010.

4. On May 9, 2011, the petitioner father called the respondent's Customer Call Center. The Running Record Comments indicate that he was not indicated on the case as the authorized representative.

5. The respondent requested that the appeal be dismissed on the basis that the petitioner did not timely request a hearing. The respondent presented that the petitioner has not contacted the respondent from the application of August 3, 2010 until the hearing request on May 18, 2011. The respondent asserted that there was no request for any Notice of Case Action to be sent to petitioner's father. The respondent provided verification that a notice was sent to the petitioner's father on May 11, 2011.

6. The petitioner's father asserted as follows. He did not receive a copy of the August 5, 2010 notice from the respondent. The notice he received was addressed to the petitioner at the nursing home. The copy of the letter was not received by the petitioner. He received the copy of that notice on April 29, 2011, when the nursing home mailed it to him. The petitioner's father opines that the funds are to be used for the petitioner's needs, the petitioner should not have to pay the nursing home, and the petitioner has no obligation to pay the nursing home. The father uses the petitioner's Social Security benefits to pay for transportation, food, cell phone bill, dental bills, medical bills, clothing and toiletries.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

8. This proceeding is a de novo proceeding pursuant to Florida Administrative Code § 65-2.056.

A. As to the issue of the respondent's motion for dismissal.

9. The definitions of an application and authorized representative are set forth in the Florida Administrative Code at 65A-1.203 and states:

> (3) Application: A specific paper, or electronic/web-based request on a designated agency media, the ACCESS Florida Application, CF-ES 2337, 05/2010, incorporated by reference in Rule 65A-1.205, F.A.C., or an ACCESS Florida Web Application, been dated and signed by the applicant or authorized/designated representative requesting that eligibility for public assistance…
>
> (9) Authorized/Designated Representative: An individual authorized to act on behalf of the household in making application for benefits.

10. The petitioner's father was indicated on the August 3, 2010 reapplication as the petitioner's authorized/designated representative.

11. The Florida Administrative Code at 65-2.043 sets forth the requirement for notice to be provided:

> ...Department or Agency, is required to provide notice and an opportunity of a hearing to any applicant or recipient when the Department's action, intended action or failure to act would adversely affect the individual's or family's eligibility for an amount or type of Financial Assistance, Medical Assistance, Social Services, or Food Stamp Program Benefits, or where action on a claim for such assistance or services is unreasonably delayed.

12. The Florida Administrative Code at Fla. Admin. Code 65-2.046 sets forth the time limits in which to request a hearing:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
> (a) The date on the written notification of the decision on an application.
> (b) The date on the written notification of reduction or termination of program benefits.

> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.
> (2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

13. The respondent did not submit a copy of the August 5, 2010 notice that the respondent sent to the petitioner's father. The respondent asserted that there was no request for any Notice of Case Action to be sent to petitioner's father. As the petitioner's father authorized/designated representative acting on behalf of the petitioner, the respondent would also need to send the petitioner's father a Notice of Case Action on August 5, 2010.

14. The evidence demonstrates that the respondent did send the notice to the petitioner on August 5, 2010. The notice that the respondent sent to the petitioner was sent to the petitioner's father by the nursing home on April 29, 2011. This indicates a possibility that the petitioner may not have received that notice through no fault of the respondent.

15. The Running Record Comment submitted by the respondent states that the petitioner's father was not indicated on the case as the authorized representative. If the petitioner's father was not entered as the authorized/designated representative on the case when the August 5, 2010 was generated, the notice would not have been sent to the petitioner's father.

16. Therefore, the hearing officer concludes that the petitioner's authorized/designated representative was not timely notified of the respondent

August 5, 2010 decision. The hearing officer is denying the respondent's motion to dismiss the appeal as the hearing was not timely requested. The hearing officer continued with the decision based on the merits of the case.

B. As to the issue of the patient responsibility of $600 a month.

17. As this was an application, in accordance with Florida Administrative Code § 65-2.060(1) the burden of proof was assigned to the petitioner.

18. The Florida Administrative Code at 65A-1.701 under "Definitions" states:

> (14) Income...For SSI-related programs refer to 20 C.F.R. §416.1100 et al. and Rule 65A-1.713.
> (21) Patient Responsibility: That portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care, ALW/HCBS or Hospice care.

19. Included and excluded income for the SSI-Related Medicaid Programs is set forth in the Florida Administrative Code at 65A-1.713: "(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq…"

20. The Code of Federal Regulations at 20 C.F.R.§416.1123 sets forth the treatment of unearned income:

> (a) When we count unearned income. We count unearned income at the earliest of the following points: When you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month...
> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
> (1) We include more than you actually receive where...You are repaying a legal obligation through the withholding of portions of your benefit amount...

21. The Florida Administrative Code at 65A-1.714 sets forth SSI-Related Medicaid post-eligibility treatment of income:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or ALW/HCBS, the department determines the amount of the individual's patient responsibility. This process is called post-eligibility treatment of income.
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance…
> (g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.
> 1. The medical/remedial care service or item must meet all the following criteria:
> a. Be recognized under state law;
> b. Be medically necessary;
> c. Not be a Medicaid compensable expense; and
> d. Not be covered by the facility or provider per diem.
> 2. For services or items not covered by the Medicaid State Plan, the amount of the deduction will be the actual amount for services or items incurred not to exceed the highest of a payment or fee recognized by Medicare, commercial payers, or any other contractually liable third party payer for the same or similar service or item.
> 3. Expenses for services or items received prior to the first month of Medicaid eligibility can only be used in the initial projection of medical expenses if the service or item was provided during the three month period prior to the month of application and it is anticipated that the expense for the service or item will recur in the initial projection period.
> 4. For the initial projection period, the department will allow a deduction for the anticipated amount of uncovered medical expenses incurred during the three month period prior to the date of application, and that are recurring (reasonably anticipated to occur) expenses in the initial projection period.
> 5. Actual incurred and recognized expenses will be deducted in each of the three months prior to the Medicaid application month when an applicant requests three months prior Medicaid coverage and is eligible in the prior month(s).

6. The initial projection period is the first day of the first month of Medicaid eligibility beginning no earlier than the application month through the last day of the sixth month following the month of approval. A semi-annual review is scheduled for the fifth month after the month approved to evaluate the recipient's actual incurred medical expenses for the prior six months.
7. For the semi-annual review, the department will request documentation of the recipient's actual incurred medical expenses for the prior six months.
a. If the recipient documents their actual expenses, staff must compare the total projected expenses budgeted with the total actual recurring expenses to determine if the projection was accurate. If the projection was overstated or understated by more than $120, the department must use the amount overstated or understated by more than $120 combined with the total expenses anticipated to recur and any non-recurring expenses incurred during the period to compute an average amount to deduct from patient responsibility for the next projection period, if possible. If an adjustment is not possible, the department must adjust the patient responsibility for each past month in which an expense was overstated.
b. If a recipient fails to document their actual expenses for the last projection period at the time of their semi-annual review, the department must assume the recipient did not incur the expense(s) which was projected. The department will remove the deduction for the next projection period and calculate the total amount of deductions incorrectly credited in the prior projection period to adjust the recipient's future patient responsibility. If an adjustment is not possible, the department must adjust the patient responsibility for each past month in which an expense was overstated.
8. The steps in subparagraph (g)7. above must be repeated for each semi-annual review.
9. Recipients must report their uncovered medical expenses timely.
a. New, recurring uncovered medical expenses must be reported no later than the tenth day of the month in which the next semi-annual review is due. If the due date falls on a weekend or holiday, the recipient must report by the end of the next regularly scheduled business day. Recurring expenses reported timely will be included in the calculation of patient responsibility beginning with the month the expense was incurred. Recurring expenses not reported timely will be included in the calculation of patient responsibility beginning the month reported and will be prorated for the remaining months of the projection period, but no adjustments in patient responsibility will be made for past months in which expenses went unreported.
b. Non-recurring uncovered medical expenses must be reported no later than the tenth day of the month in which the next semi-annual review is

> due. If the due date is a weekend or holiday, the recipient must report by the end of the next regularly scheduled business day. Non-recurring expenses reported timely will be held until the semi-annual review month and prorated over the next six-month period. Non-recurring expenses not reported timely will not be included as a deduction in the patient responsibility calculation.

22. The patient responsibility is defined by rules as that portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care. The rules indicated that the amount of patient responsibility is based on a calculation of the income and allowable verified deductions and that the gross income is to be used. The regulation sets forth that unearned income, which would include Social Security benefits, is countable income in the budget to determine patient responsibility. The father asserted that he uses the petitioner's Social Security benefits to pay for transportation, food, cell phone bill, dental bills, medical bills, clothing and toiletries. Transportation, food, cell phone bill, clothing and toiletries are not deductions in the Medicaid budget. Allowable deductions would be insurance, Medicare premiums and verified medical expenses. The reapplication did not indicate any expenses. The petitioner did not submit any medical bills into evidence. Therefore in this case, the patient responsibility would be the income of $635 less the $35 personal needs allowance for an amount of $600. As set forth in rule, $600 would be the amount the petitioner would need to pay for the petitioner's care at the nursing home. The hearing officer concludes that the respondent's action to determine the amount of patient responsibility to be $600 was within in the rules of the Program.

23. The petitioner has a right report and verify medical expenses and to have the respondent review the expenses as set forth in above rule.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this _____ day of _____, 2011,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
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