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

[redacted]

APPEAL NO. 12F-00460

PETITIONER,

Vs.

CASE NO. 1334094985

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by telephone in the above-referenced matter on February 15, 2012.

APPEARANCES

For the Petitioner: [redacted] daughter
For the Respondent: [redacted] senior eligibility worker with the [redacted] Program

STATEMENT OF ISSUE

At issue is the respondent's decision of January 9, 2012 to increase the petitioner's patient responsibility in the Institutional Care and Medicaid Program (ICP) from $394.93 monthly to $633.83 monthly effective February 2012. This increased patient responsibility occurred because the respondent had previously credited a

terminated $170.90 monthly health insurance premium in the patient responsibility calculation. Further, the respondent determines that the petitioner's patient responsibility in the ICP was understated by a total of $1,025.40 for the months of July 2011 through December 2011.

PRELIMINARY STATEMENT

By notice dated January 9, 2012, the petitioner and his wife were notified that the patient responsibility amount in the ICP increased to $633.83 monthly effective February 2012 and after. The notice also showed that the patient responsibility amount increased by $170.90 monthly because a prior incurred health insurance premium was not verified. The petitioner challenges the increased patient responsibility amount of $633.83 as well as the respondent's assertion that an increased patient responsibility amount is retroactively effective to July 2011. The respondent determined the patient responsibility amount had been understated by a total amount of $1,025.40 during the months of July 2011 through December 2011. On January 19, 2012, the petitioner timely requested an appeal on the increased patient responsibility amount effective February 2012, and the understated patient responsibility amount for the months of July 2011 through December 2011.

The petitioner's wife, [redacted] appeared as a witness for the petitioner. [redacted], business office manager with the nursing facility, also appeared as a witness for the petitioner.

FINDINGS OF FACT

1. The petitioner has resided in a skilled nursing facility since at least December 2010. The petitioner's wife lives in the community.

2. The respondent included total income of $2,043.66 for the petitioner during the months of July 2011 through January 2012. The petitioner agreed that this was the petitioner's total income during the months of July 2011 through December 2011. The respondent included total income of $2,091.66 for the petitioner during the months of February 2012 and after, as agreed by the petitioner.

3. The petitioner was previously approved to receive ongoing ICP benefits to include the months of December 2010 and after. On December 1, 2010, the petitioner's wife reported to the respondent that the petitioner's Blue Cross Blue Shield (BCBS) premium had terminated. The respondent did not act on this reported change due to the respondent's acknowledged agency error. The respondent continued to erroneously include the $170.90 monthly BCBS health insurance premium deduction in the ICP patient responsibility calculation. With this continued erroneous credit, the respondent determined the petitioner to have a $394.63 monthly patient responsibility amount payable to the nursing facility in the months of July 2011 through December 2011.

4. On July 14, 2011, the petitioner re-applied for continued approval of ICP benefits. This application listed that the petitioner continued to incur a $170.90 monthly BCBS health insurance premium expense, even though this expense had actually terminated. The respondent's eligibility processor continued the prior credit for this $170.90 monthly

BCBS health insurance expense in the patient responsibility calculation in error. The respondent determined the petitioner to have a continuing $394.63 monthly patient responsibility amount in the ICP after crediting the $170.90 monthly BCBS insurance premium.

5. In December 2011, the respondent's change unit conducted a six-month reconciliation review of the $170.90 monthly BCBS premium expense previously credited as an unreimbursed medical expense (UME). Per notice dated December 13, 2011, the respondent's change unit requested verification of any UME incurred during the last six months by a due date of January 10, 2012. The petitioner did not provide this verification. On January 9, 2012, the respondent sent notice to the petitioner that his patient responsibility amount in the ICP increased to $633.83 monthly effective February 2012 due to the removal of $170.90 monthly BCBS expense as a UME. The notice also advised that, "requesting adjustment to patient responsibility in amount of $170.90 from each month from 7/11-12/11." The notice further advised that the action was taken because the prior health insurance premium was not verified as requested.

6. The respondent determined the patient responsibility amount had been understated by a total amount of $1,025.40 during the months of July 2011 through December 2011 (or the UME had been overstated by $1025.40).

7. The petitioner challenges the increased ICP patient responsibility amount of $633.83 monthly effective February 2012. The petitioner also challenges the respondent's assertion that the patient responsibility amount should be increased

retroactively for the months of July 2011 to December 2011 due to respondent's reconciliation review.

8. The respondent asserts that the petitioner is liable for the increased patient liability amount discovered during the reconciliation process for the months of July 2011 through December 2011. The respondent referred the petitioner's case to the respondent's Office of Public Benefits Integrity (OPBI) Program for an assessment of a possible ICP overpayment for the months of January 2011 through June 2011. The petitioner expressed concern about this possible ICP overpayment action at the hearing. The available evidence does not show that the respondent's OPBI Program has made a decision on this overpayment referral as of the hearing date.

9. The petitioner's nursing home witness expressed concern about the patient responsibility determination retroactive to July 2011 in the notice dated January 9, 2012. In her experience, she has never seen this happen. This witness argued that it was believed by the petitioner and the nursing facility that the patient responsibility amount had been determined correctly by the respondent. The petitioner also expressed concern about the amount of the spousal needs allowance at the hearing, but this concern is not specifically at issue in this hearing.

CONCLUSIONS OF LAW

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

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. In accordance with Fla. Admin. Code R. 65-2.060(1) the burden of proof was assigned to the respondent.

13. Petitioner is a resident of a nursing facility and is a Medicaid recipient under the ICP. ICP eligible individuals have a patient responsibility assigned by the Department based on the individual's monthly income (see the Department's Program Policy Manual, 165-22, section 2640.0117).

14. The Agency for Health Care Administration has promulgated its Florida Nursing Facility Services Coverage and Limitations Handbook (the Handbook) in Fla. Admin. Code R. 59G-4.200. The Florida Nursing Facility Services Coverage and Limitations Handbook states in relevant part at page 2-3:

> Requirements to Receive Services…Eligibility Determination… Department of Children and Families (DCF) district staff determines eligibility for ICP. ICP eligibility must be approved for all individuals whose care will be paid for by Medicaid, including SSI recipients and individuals who were eligible for Medicaid in the community before entering a nursing facility. The possession of a Medicaid card is not proof that the individual is eligible for institutional care benefits. Eligibility determination is still required and must be done prior to billing Medicaid for services. DCF must determine and notify the facility in writing regarding the correct amount of

> the patient responsibility prior to the first billing. (See below for patient responsibility deductions.)… Patient Responsibility Deductions… Effective January 1, 2004, DCF can deduct the cost to pay for necessary medical expenses not covered by Medicaid from the patient responsibility…DCF must inform the nursing facility in writing of all changes in the patient responsibility. The facility may not make changes to the patient responsibility until it has been notified by DCF in writing.

15. The Handbook continues on page 3-1 to explain patient responsibility and states in part:

> Per Diem Payment
> Medicaid pays a daily rate for care in a Florida nursing facility. This per diem rate is calculated based on the nursing facility's annual cost report. By federal regulations, Medicaid is the payer of last resort; as such, Medicaid pays after reimbursement by all other responsible parties.
> Per Diem The per diem rate includes all services and items necessary to ensure appropriate care. The amount paid by Medicaid is the difference between the nursing facility's Medicaid rate and the recipient's patient responsibility. The patient responsibility is prorated on a daily basis by the Medicaid fiscal agent payment system.
> The nursing facility billing representative must enter the full monthly patient responsibility amount on the claim to be submitted for payment. The Department of Children and Families, Office of Economic Self Sufficiency determines the amount of the patient responsibility and sends a notice to the facility. DCF notices must be maintained at the facility and be readily available for audit purposes.

16. 42 USC § 1396a - State plans for medical assistance allows for the disregard from the patient responsibility of certain payments as follows:

> (r) Disregarding payments for certain medical expenses by institutionalized individuals
>
> (1)(A) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation

> payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including…
> (i) medicare and other health insurance premiums, deductibles, or coinsurance, and…

17. Fla. Admin. Code R. 65A-1.714(1)(7)(g) permits credit for a health insurance premium in the calculation of the ICP patient responsibility amount, as follows:

> (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.

18. 42 CFR §435.725, Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care, states in relevant part:

> (f) Determination of medical expenses—
> (1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.
> (2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.
> (3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

19. The issue before the undersigned is whether or not it is appropriate for the respondent to increase the petitioner's patient responsibility in the ICP for a prior reconciliation period, as well as increase the patient responsibility going forward. The change was due to the elimination of a deduction for a BCBS insurance premium

expense as a UME in the ICP patient responsibility calculation. Finding number 2 establishes that the petitioner reported on December 1, 2010 that the BCBS insurance premium had terminated. The evidence does not show that the petitioner incurred this expense after December 2010.

20. Since the petitioner has not incurred the BCBS health insurance premium expense since December 2010, no deduction can be allowed for this expense. Finding number 4 establishes that the respondent conducted a six-month reconciliation review in December 2011 of the UME deduction credited for the months of July 2011 through December 2011.

21. The above cited federal regulation provides for adjustments at the end of the six month prospective period. Fla. Admin. Code R. 65A-1.714(1)(g)(7) a. and b. addresses what occurs in this adjustment/reconciliation review:

> 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.** (emphasis added)

22. The language of the above cited rule permits the respondent to conduct a reconciliation review for the prior six-month period when projected UME was used. Since the respondent conducted this six-month review in December 2011, the respondent is correct to look back six months to the month of July 2011 to determine if UMEs were properly credited in the ICP patient responsibility calculation. The respondent correctly determined that the patient responsibility amount had been understated due to the erroneous inclusion of the $170.90 monthly BCBS insurance premium in each of the six months in the reconcilation time frame from July 2011 to December 2011 ($170.90 times 6 months equals a total understated patient responsibility amount of $1,025.40 for the six-month period, as also determined by the respondent notice dated January 9, 2012).

23. According to the above authorities, the Department must 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 for future months is not possible, the Department must adjust the patient responsibility for each past month in which an expense was overstated.

24. To review if the Department correctly determined that an adjustment in the future was not possible, resulting in the adjustment to the prior six months of patient

responsibiltiy, the Department's manual and relevant transmittal is cited below for the needed detail of the process.

25. The Department's Program Policy Manual, 165-22, section 2640.125.03 Uncovered Medical Expenses (MSSI), et. seq., states:

> When an individual incurs medical expenses that are not Medicaid compensable and not subject to payment by a third party, the cost of these uncovered medical expenses must be deducted from the individual's income when determining his patient responsibility. To be deducted, the medical expense only needs to be incurred, not necessarily paid.
> Uncovered medical expenses will be averaged and projected over a prospective period of, generally, no more than six-months.
> The following types and amounts of medical expenses may be deducted from an individual's income available for patient responsibility:
> 1. The actual amount of health insurance (other than Medicare) payments an individual is responsible for paying. This includes premiums, deductibles, and coinsurance charges.
> 2. The actual amount (if reasonable) incurred for medical services or items that are recognized under state law and medically necessary.
> A medical expense deduction is not budgeted when:
> 1. Medical expenses are paid by someone other than the recipient or other than someone acting on behalf of the recipient using the recipient's funds.
> 2. Payments are made to someone other than the provider.
> 3. The medical expense is for nursing facility services, including those incurred during a penalty period.
> Expenses for services received prior to the first month of Medicaid eligibility can only be used in the initial projection if the service was incurred in the three months prior to the month of application and only if the service is anticipated to recur.
> 2640.0125.02 Budgeting Expenses at Application (MSSI)
> For retroactive Medicaid assistance, budget actual medical expenses incurred in each of the three months prior to the date of application.
> For ongoing eligibility, evaluate all expenses incurred in the three months preceding the month of application and use the steps below to compute the deductible amount beginning with the month of application (if the month of application is an eligible month) and ongoing.
> Step 1 - Total all non-fluctuating (expected to recur each month) recognized expenses incurred in previous three months (for example, health insurance premiums). Calculate an average.
> Note: If there are fewer than 3 months of recurring expenses, divide by the

correct number of months, for example 2 or 1.
When health insurance (other than Medicare) is involved, and premiums are not paid monthly, determine how often paid and average to get a monthly amount.
Step 2 - Total all fluctuating recognized expenses (incurred during the previous three-month period and expected to recur at some time during the projection period.) Do not include any expense incurred in the previous three months that is not expected to recur during the projection period. Divide the total by the number of months in the projection period.
Note: The projection period is comprised of the first month of ongoing eligibility, beginning with the month of application, through the sixth month following the disposition month. This does not include retroactive months when actual expenses are budgeted.
Step 3 - Add the amounts from steps #1 and #2 together and deduct the uncovered medical expenses over the projection period.
2640.0125.03 Determining if Reconciliation is Necessary (MSSI)
Reconciliation is the process of comparing the total projected recurring expenses with the total actual recurring expenses, and accounting for an understated or overstated amount that is more than $120 in the recipient's patient responsibility budget either over the next projection period or calculating the adjustment in the actual month of discrepancy.
Reconciliation must be considered every six months after an initial projection of uncovered medical expenses and anytime a significant change is reported. This includes acquisition or loss of a recurring medical expense, discharge from a program that requires patient responsibility calculation, or discharge due to death.
To determine if reconciliation is necessary:
1. Total the projected recurring expenses (non-fluctuating and fluctuating) incurred during the previous period.
2. Subtract the actual recurring (non-fluctuating and fluctuating) incurred during the previous period.
3. If the difference is more than $120, reconciliation is necessary. (Refer to Step 2 in 2640.0125.04 to complete reconciliation). If the difference is $120 or less, reconciliation is not necessary.
2640.0125.04 Budgeting Expenses at Semi Annual Review (MSSI)
Follow the steps below to determine the new projection at each semi annual review.
Step 1 - Use the total actual recurring expenses incurred during the preceding six-month period.
Step 2 - Subtract entire overstated (or add entire understated amount) when the difference between the actual recurring expenses and the previously projected recurring expenses is greater than $120 (reference #3 in 2640.0125.03).
Step 3 - Add any recognized "one time" medical expense(s) incurred

during the preceding six months.
Step 4 - Divide the amount from (3) above by 6 to derive an average.
Step 5 - Project the average amount determined in Step 4 for the next 6 months.
Note: If step 4 results in a negative number for future patient responsibility, recalculate patient responsibility separately for each overstated month.

26. The Department also published a transmittal in June 2004 when this policy began. Transmittal NO. P-04-06-0007, June 8, 2004, Uncovered Medical Expense Deductions, states in relevant part:

> Step 6: (1) Use the total actual recurring expenses incurred during the preceding six-month period.
> (2) Subtract overstated, or add understated amount determined in STEP 5, if reconciliation is necessary.
> (3) Add any recognized "one time" medical expense(s) incurred during the preceding six months.
> (4) Divide the amount from (3) above by 6 to derive an average.
> STEP 7
> Project the averaged amount determined in STEP 6 over the next 6 months.
> **Exception: If STEP 6 results in a "negative" number for a future patient responsibility due to an overstated medical deduction in the previous projection period, patient responsibility must be recalculated and adjusted separately for each past month that resulted in an overstated medical expense.** (emphasis added)

27. The only UME used in the prior six months of patient responsibilty was the BCBS insurance premium of $170.90. This was an erroneous deduction for the entire period of time of the reconciliation review, totaling $1025.40. To apply the above reconcilation policy, the Department was required to first use the total actual recurring UME during the prior six month period which was zero. As the previoulsy projected recurring UME was greater than $120, the Department next had to subtract the entire overstated amount of the UME from zero which left a negative number. Next the Department was to add any "one time" UME incurred during the preceding six months; this was also

zero. Next, the Department was to subtract the overstated UME amount of $1025.40 from the total actual recurring expenses of zero. According to the above policy, if this total results in a negative number for future patient responsibility due to an overstated medical deduction in the previous projection period, then the Department is to recalculate patient responsibility separately for each prior overstated month. The undersigned concludes that the policy allows for adjustments in the future patient responsbility only if there are recurring medical expenses greater than the overstated UME to take the adjustment from. However, in this case, that was not possible. Therefore, the undersigned concludes that the Department followed its policy and correctly determined that the future patient responsibility could not be adjusted to take care of the prior overstated medical deduction and correctly adjusted or reconciled the prior six months of patient responsibility.

28. The respondent considered the petitioner's total $2,091.66 monthly income in the patient responsibility calculation for the months of February 2012 and after. The respondent correctly subtracted a $35 monthly personal needs allowance from this total income as permitted by Fla. Admin. Code R. 65A-1.7141(1)(a) as follows:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (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.

29. Fla. Admin. Code R. 65A-1.7141(1)(d) also permits the subtraction of a community spouse income allowance in the patient responsibility calculation, as follows:

> (d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current Food Assistance Program standard utility allowance is used to determine the community spouse's excess utility expenses.

30. The respondent provided credit of a $1,422.83 community spouse income allowance in the patient responsibility calculations. The petitioner's wife expressed concern about the amount of this allowance during this instant hearing, but this matter is not specifically at issue in this appeal. The petitioner may request a separate appeal on the calculation of the amount of this community spouse income allowance, if she disagrees with the allowance amount.

31. The petitioner expressed concern that her case had been referred to the respondent Office of Public Benefits Integrity (OPBI) due to the possibly understated patient responsibility amounts for the months of January 2011 through June 2011. Finding number 7 establishes that the respondent OPBI Program had not made decision on this overpayment referral as of the hearing date. Thus, the appeal on this specific matter is dismissed or denied as being presently premature and not yet ripe for appeal. If the respondent later makes a decision of overpayment for January 2011 through June 2011, the petitioner would retain the right to request a separate appeal on this matter, as well as the community spouse income allowance matter as described in finding number 19 above.

32. In sum, the respondent correctly considered and included the petitioner's income in the patient responsibility calculation. After the $35 personal needs allowance and the $1,422.83 community spouse income allowance was subtracted from the petitioner's total gross income, the respondent was correct to determine a $633.83 monthly patient responsbility amount in the ICP for the months of February 2012 and after. Further, the respondent was correct to increase the patient responsibility for the prior six months at issue.

33. The petitioner may elect to request separate appeal(s) on the community spouse income allowance as well as any possible future overpayment determination for the months of January 2011 through June 2011.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the appeal is denied. The Department's action is affirmed.

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 _____, 2012,

in Tallahassee, Florida.

_____
Jim Travis
Hearing Officer
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