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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88630

RESPONDENT.
_____/

APPEAL NO. 14F-09881

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 16, 2015 at 1:34pm

APPEARANCES

For the Petitioner: [redacted] wife

For the Respondent: Sharnise Jackson,
Senior Economic Self-Sufficiency Specialist

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 9, 2014 enrolling the household in the Medically Needy Program with a share of cost. The petitioner is seeking full Medicaid eligibility.

PRELIMINARY STATEMENT

The Department provided evidence on December 31, 2014 which was entered as Respondent Exhibit 1.

The hearing was reconvened on January 22, 2015 to review the petitioner's evidence that was sent to the Department January 14, 2015. This evidence was entered as Petitioner's Exhibit 1 at the reconvened hearing. The Department submitted supplemental evidence at the reconvened hearing which was entered as Respondent Exhibit 2.

The record was held open until January 30, 2015 for additional information from both parties. The Department submitted additional information on January 23, 2015 which was entered as Respondent Exhibit 3. The petitioner submitted additional documentation on January 28, 2015. The undersigned reviewed this documentation and found it to be the same information as found in Respondent Exhibit 3. It was not entered into the record.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner applied for Medicaid for himself on August 26, 2014. The household consists of the petitioner and his wife. At the time of application, the petitioner and his wife were both 64 years old. The petitioner is disabled and turned 65 on [redacted] The petitioner's wife is not disabled but turned 65 on [redacted]

2. The petitioner received Social Security Disability in the gross amount of $1875.90 per month in 2014. The petitioner's Social Security benefit amount increased to $1,907.90 per month beginning January 2015. The petitioner has been receiving Medicare since January 2012.

3. The petitioner's wife receives Social Security retirement in the gross amount of $1127.00 beginning January 2014. The amount changed effective November 2014 to $1126.90 as her Medicare began in November 2014 when she turned 65. Her Social Security gross amount increased to $1,145.90 per month beginning January 2015.

4. The petitioner's wife also receives a retirement check of $815.98 per month from AT&T. This is a lifetime benefit amount.

5. The petitioner's wife had a supplemental insurance with United HealthCare through her former employer which included prescription coverage. The company changed insurance plans and the petitioner applied for Medicaid to assist with prescription coverage.

6. New supplemental insurance coverage for the petitioner's wife has been purchased at $192 per month for supplemental and $20 for her prescriptions. New supplemental for the petitioner was purchased at $172 per month, but no prescription coverage. The new prescription plans for the petitioner either are too expensive for the plan or do not cover all of the petitioner's prescriptions.

7. The petitioner is diabetic and has a heart condition. The medications he has been prescribed are very expensive. As an example, the petitioner listed the costs of three prescriptions as: $903, $445, and $10,154.

8. The petitioner has tried to obtain additional assistance for prescription coverage through Social Security Extra Help (Shine) but was told it cannot help with some of his prescription needs.

9. The Department explained the total gross income for the petitioner and his wife exceeds the income limit of $1,154 to receive full Medicaid.

10. The Department enrolled the couple in the Medically Needy Program with an estimated share of cost, as the supplemental insurance premium had not been verified. The total gross income of $3817.98 was used to determine the share of cost. The Department deducted a $20 unearned income disregard and the Medically Needy Income Level (MNIL) of $241 to result in a share of cost of $3,556. The Department entered the unverified insurance premium of $225 as a deduction to give the petitioner an estimated remaining share of cost of $3,331. The petitioner's Medicare premium was not included in the initial determination.

CONCLUSIONS OF LAW

11. 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 § 409.285, Fla. Stat.

12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056. This concept involves the hearing officer looking at the facts from an application anew, even though not known by the Department at the time the action was taken.

13. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner.

14. Fla. Admin. Code § 65A-1.710 SSI-Related Medicaid Coverage Groups states in relevant part:

> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).
> ...
> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

15. Fla. Admin. Code § 65A-1.701 "Definitions" states in relevant part:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level **and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.**

16. The above authority explains that the MEDS-AD Demonstration Waiver is limited to individuals who are not receiving Medicare. This is the full coverage Medicaid program for aged or disabled individuals. Petitioner and his wife receive Medicare. There was no evidence the couple is receiving institutional care services, hospice services or home and community based services. The undersigned concludes the couple does not qualify for full coverage Medicaid as they are both Medicare recipients and not receiving one of the specified categories of assistance. Therefore, the Medically Needy Program for aged or disabled individuals is the correct program for the couple.

17. Fla. Admin. Code § 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria" states in relevant part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

...

(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 (2007) (incorporated by reference) et seq.,

...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. § 1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference).

...

(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

18. Federal Regulations at 20 C.F.R. § 416.121 "Types of Unearned Income" states in relevant part: "(a) Annuities, pensions, and other periodic payments. This

unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veteran's benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."

19. 20 C.F.R. § 416.1124 (c)(12), "Unearned income we do not count" states in part, "The first $20 of any unearned income in a month..."

20. Fla. Admin. Code § 65A-1.716 "Income and Resource Criteria" states in part, "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: ... Family Size 2 ... $241"

21. The findings show the household had a total gross income of $3,817.98. According to the above authorities, the Medically Needy Share of Cost is calculated by subtracting the $20 unearned disregard and the Medically Needy Income Limit (MNIL) of $241 for a couple from the total gross income of $3,817.98 to result in a $3,556 share of cost for 2014. Under de novo review, the undersigned concludes the petitioner's Medicare premium of $104.90 should have been deducted from the share of cost. In addition, the correct amount of unverified medical insurance premiums that should be included was $384. These expenses would have allowed the share of cost to be reduced from $3,556 to an estimated $3,068 pending insurance premium verifications being submitted.

22. The undersigned concludes for November and December 2014 the share of cost as determined in #21 of $3,556 should have the reduction of both the petitioner and his wife's Medicare premiums totaling $209.80 as well as $384 in estimated supplemental insurance premiums. These expenses would allow the share of cost to be reduced to an estimated share of cost of $2,962.

23. Beginning January 2015, the findings show the total gross income for the household is $3,867.98. The undersigned concludes the $20 unearned income disregard and $241 MNIL must be subtracted to result in the share of cost of $3606.98. The Share of Cost is reduced by the Medicare premiums for the petitioner and his wife of $104.90 each (total $209.80) as well as the estimated supplemental premiums of $384 to reach an estimated share of cost of $3,013.

24. In review of the budgets presented, the undersigned notes the reduction in the estimated share of cost has been made effective March 2015. However, previous months need to be corrected. Furthermore, when the petitioner submits verification of the insurance premiums to the Department, the actual premium amount can be updated so that the share of cost is no longer estimated.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied in part as the couple does not qualify for full Medicaid under the MEDS-AD program. The appeal is also granted in part. The Department is to correct the estimated share of cost based on correct inclusion of Medicare premiums and medical insurance premiums reported.

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 petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 27 day of February, 2015,

in Tallahassee, Florida.

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency