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

FILED
Nov 24, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88778

RESPONDENT.
_____/

APPEAL NO. 15F-02609

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice and agreement, this hearing first convened before Hearing Officer Patricia C. Antonucci in Gainesville, Florida on July 10, 2015 at approximately 10:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's Son/Power of Attorney

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist
(via teleconference) (ESSS II), Department of Children and Families

STATEMENT OF ISSUE

Originally at issue was whether Respondent, the Department of Children and Families (DCF) properly calculated the amount of Petitioner's patient responsibility under his Institutional Care Placement (ICP) Medicaid. At hearing, this issue was further narrowed to whether Respondent should deduct from this patient responsibility

Petitioner's expenses for prescription medications currently paid out-of-pocket. Petitioner bears the burden of proving, by a preponderance of the evidence, that these expenses should be considered when calculating his Medicaid budget.

PRELIMINARY STATEMENT

By notice dated June 26, 2015, both parties were notified that this matter would convene for an in-person hearing on July 10, 2015. On the designated date, the undersigned hearing officer, [redacted] (Petitioner's son/representative), and Lynn Dann, ESS Supervisor with DCF, appeared in a conference room in Gainesville, Florida. Matthew Lynn, representing Respondent, joined the hearing via teleconference.

Respondent's Exhibits 1 through 6, inclusive, and Petitioner's Exhibits 1 through 5, inclusive, were entered into evidence. Following testimony, the record was held open to provide Respondent with a copy of documentation presented by Petitioner at hearing and allow for response to same. Respondent also supplemented the record with documentation referenced during hearing but not submitted into evidence: a Notice of Case Action dated July 13, 2015 (5 pages).

Via Order to Reconvene, these pages were copied to Petitioner, and this matter was set to reconvene for hearing on August 27, 2015 to discuss the content of the supplemental Notice. Due to an emergency hospitalization, Petitioner was unable to attend the hearing on August 27, 2015. As such, the reconvened hearing was rescheduled for October 7, 2015.

During telephonic hearing on October 7, 2015, Petitioner was again represented

by [redacted] and the Department, by Matthew Lynn. Both parties testified regarding the July 13, 2015 Notice, and the issue of Petitioner's out-of-pocket expenses for prescription drugs. The record was held open until October 16, 2015 to receive copies of Petitioner's prescription bills/invoices. This supplement was timely received, and the record closed. All supplemental evidence has now been entered as follows:

- Respondent's Exhibit 7 (5 pages): July 13, 2015 Notice of Case Action;
- Petitioner's Composite Exhibit 6 (total 14 pages): Cover e-mail dated October 12, 2015 (1 page); Statement from Geriatrics and Internal Medicine Practices (1 page); information and invoices from Omnicare Central Billing Center (9 pages); cover letter and notice from Florida Department of Management Services State Group Insurance (3 pages).

FINDINGS OF FACT

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

1. Petitioner is an [redacted] year-old male, born [redacted] He was admitted to a nursing home facility (NHF) in September of 2010, and has been receiving ICP benefits for many years. He is currently enrolled in a Medicaid Long Term Care (LTC) plan through Sunshine Health.

2. In December of 2014, Respondent sent a letter to Petitioner, notifying him of the need to recertify for ICP Medicaid, and requesting documentation to assist in determining Petitioner's eligibility. In response, Petitioner's son submitted to DCF financial documentation regarding Petitioner's life, health, and dental insurance, as well as his bank statements.

3. Via Notices of Case Action dated January 7, 2015 and March 9, 2015, Respondent informed Petitioner of changes to his patient responsibility (PR) – that is, the amount Petitioner must directly contribute towards his care at the NHF. Both Notices proposed to increase the monthly PR amount.

4. On or about March 24, 2015, Petitioner requested a hearing to challenge these increases; however, both the January and March Notices have since been superseded, and the patient responsibility adjusted, accordingly.

5. At hearing, both parties confirmed that Petitioner's sources of income include a pension, an IRA, and social security benefits, which total to $6,499.85 per month in gross, unearned income. He has a Qualified Income Trust (QIT), which Respondent concedes is properly funded, thus reducing his gross countable income to $1,036.55 per month.

6. Although Petitioner sustains substantial federal withholdings on both his pension and his IRA, DCF utilizes only gross income (plus standardized deductions) in its budgetary calculations. As such, federal withholdings are not considered within the Medicaid budget. Petitioner otherwise agrees that Respondent has properly calculated Petitioner's income.

7. As Petitioner's gross countable income is $1,036.55 and the maximum income for SSI-Related Medicaid eligibility is $2,199.00, Petitioner qualifies for ICP coverage.

8. The Petitioner's monthly expenses include court-ordered spousal support of $2,597.00, Blue Cross and Blue Shield (BCBS) health insurance of $719.22, and dental insurance of $90.00. Per DCF case notes, Petitioner's dental insurance was briefly

discontinued on or about December 31, 2014, but reestablished in March, 2015. Petitioner also incurs out-of-pocket co-pays for monthly prescriptions.

9. To determine Petitioner's PR, Respondent took his gross income ($6,499.85), and reduced same by a personal needs allowance of $105.00, resulting in $6,394.85. Respondent then applied additional deductions for spousal support, BCBS premiums, and dental insurance, grouping all three under "uncovered medical expenses" of $3,406.22.[1] For the months when Petitioner did not have dental coverage, the uncovered medical expenses were $90.00 less, or $3,316.22.

10. As Petitioner was allotted a deduction for his court-ordered spousal support, he was not also given a community spouse income allowance. Petitioner does not contest this issue, but received clarification from Respondent regarding the community spouse allowance option.

11. Via Notice of Case Action dated July 13, 2015, DCF memorialized the adjustments previously entered into Petitioner's budgets, as discussed at hearing. For the months of January and February, 2015, when Petitioner did not pay a $90.00 dental insurance premium, Petitioner's patient responsibility was $3,078.63 ($6,394.85 - $3,316.22.). For March through July, 2015, the patient responsibility was $2,988.63 ($6,394.85 - $3,406.22).

[1] Respondent explained that in the past, the Department did include a deduction for Petitioner's court-ordered spousal support in Petitioner's budget; however, because of the way this deduction was input into DCF's budgeting system, the spousal support deduction did not repopulate when the budget was re-run each month (or at recertification). In order to override this system default, Respondent entered the spousal support as an uncovered medical expense. Respondent believes this should prevent the system from deleting the spousal support in subsequent budgeting months.

12. Petitioner notes that he's encountered great frustration in trying to communicate with the Department regarding this case, often receiving Notices from the Department the day before an action required by said Notice is due. Petitioner states that, historically, he only begins to receive responses and assistance with case management *after* filing for an appeal. He has been able to resolve many of his concerns in the instant appeal since speaking directly with Matthew Lynn, but is concerned that the same confusion which resulted in improper changes to the PR will recur once the appeals process ends and his case returns to a non-appeal unit at DCF.

13. While Petitioner does not dispute that Respondent's adjusted calculations are correct, he believes that because he is paying for prescription medications (out of the QIT), the cost of same should be deducted from his budget as an additional, uncovered medical expense.

14. In support of his position that these are out-of-pocket expenses, Petitioner proffered correspondence (e-mails) from his LTC Plan, Sunshine Health, documenting that Sunshine does not offer prescription drug coverage. Sunshine's correspondence refers Petitioner to either Medicare or BCBS (his primary insurance) to assist with the costs of prescriptions.

15. Petitioner contends that, although he receives a discounted rate on prescriptions through BCBS, he still incurs monthly co-pays for his medications. It is Petitioner's understanding that BCBS is already contributing as much as it will towards the cost of prescribed medications. Petitioner further contends that he is not currently enrolled in Medicare Part D (prescription coverage).

16. Respondent concedes that Petitioner is not enrolled in Medicare Part D, and has also confirmed with Sunshine Health that they will not pay for Petitioner's prescriptions. Respondent further acknowledges that the NHF in which Petitioner resides does not have its own pharmacy. However, it is Respondent's position that because Petitioner has "full Medicaid," someone – either Sunshine or BCBS or Medicare – should be billed for and pay his prescription costs. Respondent contends that unless Petitioner submits documentation to show BCBS has denied a request to cover these costs, the Department cannot consider them as true unpaid medical expenses.

17. In terms of Petitioner's concern regarding the Department's handling of his case, Mr. Lynn encouraged Petitioner to sign up for e-mail alerts, so that he will receive immediate copies of all notifications issued by the Department. Mr. Lynn also encouraged Petitioner to continue to contact him, directly, if he encounters trouble in the future – even after his case is no longer in appeals.

18. Following hearing, Petitioner timely supplemented the record with copies of six (6) invoices for his prescription coverage, which he paid in May through October of 2015. Said invoices, from Omnicare Pharmacy Services, include a notation within the description field, "Co-pay is the financial responsibility of the covered beneficiary/guarantor." These invoices reflect monthly charges of: $107.68, $219.50; $258.50; $105.95; $81.11; and $82.22, respectively.

19. Along with these invoices, Petitioner submitted a bill for services at Geriatrics and Internal Medicine Practices; however, in the cover letter filed along with this supplemental documentation, Petitioner's son notes this is "[a] pending bill for my Dad

from his physician for services (I did not mention it at the hearings, but it is a bill that is unpaid. I am going to check with his various providers to see if they will cover)."

CONCLUSIONS OF LAW

20. 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.

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

22. The burden of proof is assigned to the Petitioner, pursuant to Fla. Admin. Code R. 65-2.060(1), as Respondent increased the PR following recertification (*see also* the ACCESS Florida Program Policy Manual, Section 0840.0100, **Eligibility Reviews (MSSI, SFP)**).

23. The standard of proof for an administrative hearing is "preponderance of the evidence," as provided by Fla. Admin. Code R. 65A-2.060(1).

24. At issue is Respondent's determination of Petitioner's PR under ICP Medicaid. As pertains to the PR, Petitioner disputes only the fact that his prescription costs are not included in his budget. As such, the undersigned's review is largely limited to this issue.

25. For the Institutional Care Medicaid Program, 42 C.F.R. § 435.603 sets forth allowable deductions in calculating the PR:

> c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

> (1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.
> ...
> (4) *Expenses not subject to third party payment.* 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 charges; and
> (ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

26. Fla. Admin. Code R. 65A-1.7141(1) echoes the language of the C.F.R., further explaining, as follows:

> (1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:
> (a) A Personal Needs Allowance (PNA) of $105. Individuals residing in medical institutions and intermediate care facilities shall have $105 of their monthly income protected for their personal need allowance.
> ...
> (i) Uncovered medical expense deduction. The following policy will be applied in considering medical deductions for institutionalized individuals and individuals receiving HCBS services to calculate the amount allowed for the uncovered medical expense deduction:
> 1. For institutionalized persons or residents of medical institutions and intermediate care facilities, the deduction includes:
> a. Any premium, deductible, or coinsurance charges or payments for health insurance coverage.
> b. For other incurred medical expenses, the expense must be for a medical or remedial care service and be medically necessary as specified in subsection 59G-1.010(166), F.A.C., and be recognized in state law. For medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be the amount of the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial

payors, or any other third party payor, for the same or similar item, care, or service.

2. The expense must have been incurred no earlier than the three month period preceding the month of application providing eligibility.

3. The expense must not have been paid for under the Medicaid State Plan.

4. Other health insurance policies, including long term care insurance, are considered to be the first payor for medical items, care, or services covered by such policies and the remaining items can be used as an uncovered medical expense deduction. Therefore, to be deducted from the individual's income, the individual must demonstrate that other insurance does not cover such medical items, care, or services.

5. The medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty is limited to zero.
(emphasis added)

27. In accordance with this legal authority, the ACCESS Florida Program Policy Manual specifies, in part, at Section 2640.0125.01 (**Uncovered Medical Expenses (MSSI)**):

Policies found in passages 2640.0125.01 through 2640.0125.05 apply to the ICP, ICP MEDS, ICP Hospice, Community Hospice, Long-Term Care Diversion Waiver Program, the Assisted Living Waiver Program, and PACE.

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.
> (emphasis added)

28. Respondent's inclusion of Petitioner's BCBS monthly premium and his dental insurance as uncovered/unreimbursed medical expenses is clearly in compliance with the above-reference authority.

29. Petitioner, himself, admits that the invoice from Geriatrics and Internal Medicine Practices may be reimbursed after he submits same to Petitioner's BCBS or Long Term Care (Sunshine Health) coverage providers. As such, this invoice currently falls into the category of a medical expense that may be "Medicaid compensable" or "subject to payment by a third party." Absent further documentation, the invoice cannot be considered an uncovered medical expense.

30. With regard to Petitioner's prescriptions, however, Petitioner has shown that his Long Term Care plan, Sunshine Health, will *not* provide coverage or reimbursement. Petitioner is not currently enrolled in a Medicare prescription coverage plan, so said prescriptions will not be covered by Medicare, either. Petitioner's BCBS insurance is contributing to the cost of prescription drugs, insofar as it reduces Petitioner's out-of-pocket costs to monthly co-pays. However, Petitioner has submitted documentation which clearly shows that he, himself (i.e., through the QIT, on his behalf) is paying these monthly co-pays, and is not receiving reimbursement for same. This situation falls squarely within the parameters of Fla. Admin. Code R. 65A-1.7141(1)(i)(4) and The Department's Program Policy Manual at Section 2640.0125.01.

31. To budget for Petitioner's uncovered prescription expenses, the undersigned has followed the requirements of Section 2640.0125.01, averaging the prescription

costs by adding the six months of bills provided ($107.68 + $219.50 + $258.50 + $105.95 + $81.11 + $82.22 = $854.96) and dividing the total by six. This results in a monthly uncovered medical expense for prescriptions (only) of $142.49.

33. Adding this additional $142.49 uncovered medical expense to the $3,406.22 expenses (including dental) already calculated by Respondent results in total monthly uncovered medical expenses of $3,548.71 for months during which Petitioner paid a dental insurance premium – i.e., March through July, 2015. For January and February 2015, when the dental premium was not paid, Petitioner's total uncovered medical expenses are $3,316.22 +$142.49, or $3,458.71.

34. For the months of January and February of 2015, Petitioner's PR is calculated as follows:

$6,499.85 (total gross income)
- $105.00 (personal needs allowance)
- $3,458.71 (total uncovered medical expenses + spousal support)

$2,936.14 Patient Responsibility

For the months of March through July, 2015 (and ongoing), the PR Is:

$6,499.85 (total gross income)
- $105.00 (personal needs allowance)
- $3,548.71 (total uncovered medical expenses, including dental + spousal support)

$2,846.14 Patient Responsibility

35. Respondent is directed to adjust Petitioner's monthly Patient Responsibility according to the calculations set forth, above, and to continue calculating the budget in this manner until such time as Petitioner no longer pays out-of-pocket co-payments to obtain his prescription drugs.

36. Petitioner is reminded that he must report to DCF any change in coverage of his

prescriptions -- particularly if he obtains Medicare coverage, such that he no longer pays an out-of-pocket co-pay. Should Petitioner wish for any other unpaid medical expenses to be considered, he must supply these to the Department for consideration.

37. Although the undersigned acknowledges Petitioner's frustration with the Department's non-appeal unit caseworkers and the difficulty he has obtained in attempting to communicate with Department to resolve issues without necessitating hearing, the hearing officer has no jurisdiction over these customer service issues. The undersigned commends Mr. Lynn for his dedication to this case, and for encouraging Petitioner to reach out to him, directly, or to utilize the client relations number provided at hearing, should future problems arise.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby GRANTED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. 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, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 24 day of November, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
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