The Delaware Code (31 Del. C. §520) provides for judicial review of hearing decisions. In order to have a review of this decision in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections can be made.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

In re: DCIS No. 000000000

Ms. Smith

Appearances: Ms. Smith, pro se, Claimant

Kristen Mears, Sr. Social Worker/Case Manager, Team #720, Division of Social Services
Diane Earley, Supervisor, Division of Social Services

I.

Ms. Smith ("Claimant") opposes a decision by the Division of Social Services ("DSS") to deny her Medical Assistance.

The Division of Social Services ("DSS") contends that the Claimant has comprehensive health insurance, and therefore is not eligible for Medicaid for Uninsured Adults.

II.

On June 20, 2011, DSS sent the Claimant a Notice to Deny Your Medical Assistance.

On June 28, 2011, the Claimant filed a request for a fair hearing. (Exhibit 2)

The Claimant was notified by certified letters dated July 12, 2011 and August 2, 2011, that a fair hearing would be held on August 29, 2011. The hearing was conducted on that date in Georgetown, Delaware.

This is the decision resulting from that hearing.

III.

At hearing, DSS testified that when the Claimant submitted her application for Medical Assistance, she provided current paystubs from her employer, the Sussex City Council, identifying

that she was paid a biweekly gross income of $930.50[1]. In addition, DSS testified, the Claimant indicated that she had comprehensive health insurance through a third party. As a result, DSS testified, the Claimant was ineligible for Medicaid for Uninsured Adults benefits.

At the hearing, the Claimant testified that she did have other health insurance.[2]

According to the Division of Social Services Manual ("DSSM") 16110, states must provide medical assistance to certain mandatory categories of individuals and are permitted to cover optional categories of individuals. On May 17, 1995, legislation provided for a demonstration waiver that extends Medicaid coverage to uninsured individuals age 19 or over with income at or below 100% of the federal poverty level who are not categorically eligible. Individuals who receive long term care services (nursing facility and home and community based waivers), who have comprehensive health insurance as defined in this section, who are entitled to or eligible to enroll in Medicare, or who have coverage through Military Health Insurance for Active Duty, Retired Military, and their dependents are excluded from this category of assistance created under the demonstration waiver.

Pursuant to DSSM 16220.2.1, uninsured individuals age 19 or over may be found eligible as a noncategorical adult in the expanded Medicaid population under the demonstration waiver. However, there is a separate technical eligibility requirement for adults age 19 or over: DSSM 16220.4 holds that in order to be eligible under the Adult Expansion Medicaid program, the individual must be uninsured. According to DSSM 16220.4, "an uninsured individual is defined as an individual who does not have Medicare, Military Health Insurance for Active Duty, Retired Military, and their dependents, or other comprehensive health insurance. An adult who is entitled to or eligible to enroll in Medicare or who has Military Health Insurance for Active Duty, Retired Military, and their dependents or who has any comprehensive health insurance, cannot be eligible for Medicaid as a non categorical adult under the demonstration waiver."

Pursuant to DSSM 16230.1.1, DSS is only permitted to utilize gross income, and not net income (after expenses), for purposes of eligibility. As this benefit is based solely on income, there are no deductions made for medical or other expenses and a person's medical condition is not taken into consideration when determining eligibility.

According to DSSM 16250, in order to qualify for Medicaid for Uninsured Adults, after applying appropriate disregards to income, DSS is instructed to compare the countable family income to

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[1] I note that as bi-weekly income, the Claimant's calculated monthly gross income from wages came to be $2,009.88 ($930.50 X 2.16 = $2,009.88). In addition, DSS added at least $609.24 in child support payments received from the Division of Child Support Enforcement, resulting in a minimum gross monthly income of $2,619.12 ($2,009.88 + $609.24 = $2,619.12). As explained in the related decisions for the Claimant's food benefits and child care benefits, the Claimant received three (3) child support payments of $304.62 in the month of May, for a total of $913.86 ($304.62 X 3 = $913.86). It is unclear whether DSS utilized May's child support payments or the payments received for June (i.e. $609.24).

[2] The hearing itself dealt with issues arising from the Claimant's denial of medical assistance, reduction in her food benefits, and reduction in her child care benefits. The Claimant testified that the amount she pays for health insurance was not calculated into her food benefit or child care benefit cases.

the income eligibility standard for the budget unit size. The income eligibility standard for uninsured adults is family income at or below 100% of poverty.

According to Administrative Notice A-15-2010, 100% of the federal poverty level for a household of three (3) is equal to $1,526.00 per month.

In this instance, DSS testified that the Claimant and her dependent children were not eligible for Medicaid because the Claimant had comprehensive health insurance. The Claimant conceded that she had other comprehensive health insurance. DSSM 16220.4 specifically holds that an individual (and his or her dependents) is not eligible under the adult expansion Medicaid program if that person has comprehensive health insurance. As DSS' testimony shows that the Claimant had comprehensive health insurance, the Claimant is deemed to be "insured." As a result, the Claimant cannot fall within the waiver exception outlined in DSSM 16110. Therefore, as the testimony indicates that the Claimant was insured at the time of application, she is not eligible for the adult expansion, Medicaid for Uninsured Adults program.

Based upon the information provided, DSS correctly determined that the Claimant was not eligible for the Medicaid program. As a result, the Claimant was properly sent a Notice to Deny Your Medical Assistance. I conclude that substantial evidence supports DSS' decision to deny the Claimant's medical assistance benefits.

IV.

For these reasons, the June 20, 2011 decision of the Division of Social Services to deny the Claimant's Medical Assistance benefits is AFFIRMED.

Date: September 22, 2011

MICHAEL L. STEINBERG, J.D.
HEARING OFFICER

THE FOREGOING IS THE FINAL DECISION OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

September 22, 2011
POSTED

cc: Ms. Smith
Kristen Mears, DSS, Team 720
Diane Earley, DSS

EXHIBITS FILED IN OR FOR THE PROCEEDING

EXHIBIT #1 – Copy of DSS Fair Hearing Summary consisting of two (2) pages dated July 5, 2011.

EXHIBIT #2 – Copy of the Claimant's request for a fair hearing date-stamped June 28, 2011, consisting of one (1) page.

EXHIBIT #3 – Copy of a Division of Child Support Enforcement Account Statement for the Claimant, dated June 29, 2011, consisting of one (1) page.