	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. 0000000000

Ms. Smith

Appearances: Ms. Smith, pro se, Appellant
Mr. Smith, Appellant's Father

Melinda Hudson, Supervisor, Team #805, Division of Social Services
Barbara Best, Social Worker/Case Manager, Team #805, Division of Social Services

I.

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

The Division of Social Services ("DSS") contends that the Appellant has turned nineteen (19) years old and has comprehensive health insurance, and therefore is not eligible for Medicaid for Uninsured Adults.

II.

On May 6, 2011, DSS sent the Appellant a Notice to Close Your Medical Assistance, effective May 31, 2011. (Exhibit 3)

On May 27, 2011, the Appellant filed a request for a fair hearing, in which she requested that assistance continue. (Exhibit 2) According to the fair hearing summary dated June 7, 2011, assistance has not continued. (Exhibit 1)

The Appellant was notified by certified letter dated June 29, 2011, that a fair hearing would be held on July 18, 2011. A Continuance was granted on July 20, 2011. The Appellant was notified by certified letter dated August 16, 2011, that a fair hearing would be held on August 30, 2011. The hearing was conducted on that date in Newark, Delaware.

This is the decision resulting from that hearing.

III.

At hearing, DSS testified that the Appellant's benefits were initially closed because she had turned nineteen (19) years old on April 21, 2011. DSS testified that although the Appellant requested that her benefits continue, DSS could not determine how to do so: As the Appellant was nineteen (19) years old, DSS testified, the only program she could be eligible for would be Medicaid for Uninsured Adults. However, DSS testified, as the Appellant had health insurance coverage through her parents, she was not eligible for Medicaid for Uninsured Adults. As a result, DSS testified, the Appellant's medical assistance benefits were not continued.[1]

The Appellant's father testified that although his daughter had been at least partially covered under his managed care program when she turned eighteen (18), his health insurance is set to end on September 1, 2011. The Appellant's father testified that he informed DSS that his employment—and therefore his health insurance—was in limbo.[2] The Appellant's father testified that the therapy his daughter was receiving before her medical assistance benefits ended were not supported through his health insurance. As a result, he testified, his daughter returned to a provider in Rockford, Delaware. The Appellant's father testified that his daughter's medical assistance benefits covered one third of the cost of care this his private health insurance did not cover. The Appellant testified that she suffers from mental illness, and accrued substantial out-of-pocket expenses during the pendency of this hearing.

According to the Division of Social Services Manual ("DSSM") 16220.2 effective October 1, 1992, children up to age 18 may be categorically eligible. Effective July 1, 1993, individuals up to age 19 may be categorically eligible. Effective March 1, 1996, uninsured adults (age 19 and over) may be eligible under the demonstration waiver. DSSM 16220.2.1 identifies that an adult is defined as an individual age 18 or over. Individuals who are age 18 but under age 19 may be found categorically eligible under the poverty level program. Under the demonstration waiver, uninsured individuals age 19 or over may be found eligible as a noncategorical adult in the expanded Medicaid population.

Pursuant to DSSM 16290, children may remain categorically eligible for the poverty level program until the last day of the month in which they turn 19 years old unless family income exceeds the applicable limit. If the child is an inpatient in a hospital or long-term care facility receiving covered services at the time and he or she would lose categorical eligibility because of age (turning one, 6 or 19), eligibility under the poverty level program continues until the child is discharged. Individuals turning age 19 will be reviewed for eligibility under the *Diamond State Health Plan* as non-categorical uninsured adults or for other potential Medicaid eligibility.

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[1] DSS testified that even after consulting a supervisor, they could not determine how to get the Appellant's medical assistance benefits to continue, as she was no longer eligible for either her previous program or the Medicaid for Uninsured Adults program.

[2] DSS affirmed that the Appellant's father did inform them that his employment was not stable; however, DSS testified, they were not informed that his health insurance would end on a specific date.

DSSM 16110 identifies that 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."

In this instance, DSS testified that the Appellant was no longer eligible for the medical assistance benefits she was receiving because she had turned age nineteen (19). In addition, DSS testified that the Appellant was not eligible for the Medicaid for Uninsured Adults program because at the time her coverage lapsed, she had health insurance through her father's private insurer. The Appellant did not contest this testimony: Rather, the Appellant and her father acknowledged that the Appellant did have health insurance through her father's employer. DSSM 16220.4 specifically holds that an individual is not eligible under the adult expansion Medicaid program if that person has comprehensive health insurance. As DSS' testimony shows that the Appellant had comprehensive health insurance at the time the notice affecting her medical assistance benefits was made on May 6, 2011, the Appellant is deemed to be "insured." As a result, the Appellant cannot fall within the waiver exception outlined in DSSM 16110. Therefore, as the testimony indicates that the Appellant was insured at the time she became ineligible for her previous program, she is not eligible for the adult expansion, Medicaid for Uninsured Adults program.

Based upon the information provided, DSS correctly determined that the Appellant was no longer eligible for her age-based prior Medicaid program, and was not eligible for the Medicaid for Uninsured Adults program. As a result, the Appellant was properly sent a Notice to Close Your Medical Assistance. I conclude that substantial evidence supports DSS' decision to close the Appellant's medical assistance benefits. As the Appellant's health insurance through her father has now ended, she is encouraged to re-apply for medical assistance benefits.

Further, because the Appellant filed her request for a fair hearing before the effective date of the closure of her medical assistance benefits, her medical assistance benefits should have been

continued at their prior level through the pendency of this case. According to DSSM 5308, if the recipient requests a hearing within the timely notice period, assistance will not be suspended, reduced, discontinued, or terminated (but is subject to recovery by the agency if its action is sustained on appeal) until a decision is reached after a fair hearing, unless the recipient specifically requests reduction or discontinuance, or if a listed exception applies. In this instance, the Appellant's request for a fair hearing was submitted before May 31, 2011, the effective date of her medical assistance benefit closure. As a result, DSS should have continued her benefits during the pendency of this proceeding. The Appellant is urged to report the total of her out-of-pocket medical expenses to her caseworker, so she can be reimbursed for those expenses.

IV.

For these reasons, the May 6, 2011 decision of the Division of Social Services to close the Appellant's Medical Assistance benefits effective May 31, 2011 is AFFIRMED. DSS is instructed to make prompt corrective payments pursuant to DSSM 5501.

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
Melinda Hudson, Team #805, DSS
Barbara Best, Team #805, DSS

EXHIBITS FILED IN OR FOR THE PROCEEDING

EXHIBIT #1 – Copy of DSS Fair Hearing Summary consisting of two (2) pages dated June 7, 2011.

EXHIBIT #2 – Copy of the Appellant's request for a fair hearing date-stamped May 27, 2011, consisting of one (1) page.

EXHIBIT #3 – Copy of the Notice to Close Your Medical Assistance dated May 6, 2011, consisting of four (4) pages.