**BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS**

**STATE OF GEORGIA**

**\_\_\_\_\_\_\_\_\_\_\_\_\_, )**

**Petitioner, ) DOCKET NO.**

**) OSAH-DFCS-NH-1337030-28**

**v. ) Woodard**

**)**

**DEPARTMENT OF HUMAN )**

**SERVICES, DIVISION OF FAMILY )**

**AND CHILDREN SERVICES, )**

**Respondent. )**

**INITIAL DECISION AND ORDER OF REMAND TO AGENCY**

**I. Introduction**

Petitioner **\_\_\_\_\_\_\_\_\_\_\_\_\_** requested a hearing in response to Respondent’s action denying her application for Nursing Home Medicaid for the months of October 2012 through the end of January 2013. A hearing was held before the undersigned administrative law judge (“ALJ”) of the Office of State Administrative Hearings (“OSAH”) on May 17, 2013 at Cherokee County Justice Center, Canton, Georgia. Petitioner was represented by Eric Johnson, Attorney at Law, Woodstock. Jerre Johnson, a Medicaid eligibility specialist with Long-Term Care Aged, Blind, and Disabled (“ABD”) Medicaid Unit, State Division of Family and Children Services, Atlanta, appeared on behalf of the Department.

For the reasons set forth below, the basis for denial is **REVERSED** and the decision is **REMANDED** to the Department of Human Services to continue processing the application based on the time deadlines stated below.

**II. Findings of Fact**

1.

Petitioner has resided at Canton Nursing Center in Cherokee County since January 2012. On October 15, 2012, she applied for Medicaid benefits under the “Nursing Home” class of assistance through the Division of Family and Children Services, Department of Human Services (hereafter “DFCS” or “the Department”). To determine Petitioner’s potential eligibility for Medicaid, DFCS requested that she verify her monthly income. Petitioner informed DFCS that she received $1048.90 per month in Social Security benefits and $1094.00 per month in U.S. Department of Veterans’ Affairs (“VA”) benefits, for a total of $2142.90 per month. (Testimony of Jerre Johnson; Exhibit P-3).

2.

A portion of the VA benefits are classified as “Aid and Attendance” payments (hereafter “A&A”). A&A payments are not counted as “income” in the Medicaid budget.[[1]](#footnote-1) DFCS requested that VA provide a breakdown of Petitioner’s benefits. VA verified the total benefit Petitioner receives each month, but refused to provide DFCS with information on what portion of Petitioner’s benefits were A&A payments. DFCS did not ask Petitioner, her authorized representative, or Canton Nursing Center for help in verifying what portion of the VA payment is attributable to A&A. (Testimony of Jerre Johnson; Exhibit P-3.)

3.

Because DFCS did not know how much of the VA payment was exempt as A&A, it counted the entire VA payment in the Medicaid budget. Petitioner’s total monthly income of $2142.90 exceeded the Medicaid “Cap” of $2094.00 for calendar year 2012 for a nursing home resident. DFCS issued a denial notice dated December 26, 2012 to inform Petitioner and Canton Nursing Center that the application was denied as “over income.” DFCS did not consider whether Petitioner met all other criteria for Medicaid eligibility, but instead stopped processing her application once it concluded that she was over the income cap. *Medicaid Manual* § A1-1; (Testimony of Jerre Johnson; Exhibit P-4.)

4.

In a letter dated January 18, 2013, Petitioner appealed DFCS’ decision to deny her application. Petitioner subsequently provided DFCS with documentation from VA which confirmed that $410.00 of her monthly benefits during the period October 2012 to December 2012 were attributable to A&A. Petitioner was later informed by VA that her benefits would increase to $1113.00 per month as of January 1, 2013, with $416.00 per month attributable to A&A. (Exhibits P-1, P-3, P-7, P-8, P-9)

5.

The parties stipulated that A&A benefits are not considered income when determining eligibility for Medicaid. The parties also stipulated that for purposes of determining Medicaid eligibility, Petitioner’s income for October through December 2012 after deducting A&A was $1732.00 per month, which was under the Medicaid Cap. [[2]](#footnote-2) Further, the evidence produced at the hearing shows that Petitioner’s non-A&A VA benefits and her Social Security income in 2013 is also under the Medicaid Cap.

1. **Conclusions of Law**

1.

Because this matter involves the denial of an application for Medicaid benefits, Petitioner bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07(d) (cited hereafter as “OSAH Rule \_\_\_ ”). The standard of proof is a preponderance of the evidence. OSAH Rule 21(4).

2.

There are two disputes in the case before this Court: (1) whether Petitioner must reapply for benefits while the Department preserves her original application date, and (2) whether DFCS can deny Petitioner’s application on other grounds upon further processing of her application. Each will be addressed in turn below.

*a. Petitioner need not reapply for Medicaid.*

3.

DFCS concedes that Petitioner was not, in fact, over income for the period October-December 2012, and that the application was denied solely because A&A benefits were counted as income in the Medicaid budget. However, DFCS relies on section 2060 of the *Medicaid Manual* to support its argument that Petitioner must still reapply. The relevant provision states as follows:

A new signed application is required [when] . . . [a]n application was previously correctly denied due to failure to provide required verification. [Applicant] wants to reapply in a subsequent month. Although the application date of the first application is protected, have the [applicant] sign another application for the subsequent month(s) unless there is good cause for not initially providing the verification.

*Medicaid Manual* § 2060-2 (emphasis added). There are several reasons that, despite this provision, there is no need for Petitioner to reapply. First, DFCS did not correctly follow its own procedure in denying Petitioner’s application for failure to provide verification. According to the *Medicaid Manual*, the Department should have sent Petitioner a list of the information it needed and established a reasonable deadline for returning the necessary documentation. *Medicaid Manual* § 2060-5. At that point, if Petitioner experienced difficulty meeting the deadline, the caseworker should have collaborated with her to obtain the information. *Id.* In the alternative, if Petitioner did not return the documentation by DFCS’ deadline, and good cause for such failure was not established, then DFCS would be justified in denying the application. Instead, DFCS attempted to establish which portion of Petitioner’s income constituted A&A benefits by contacting the VA. When the VA subsequently refused to provide a breakdown of benefits, DFCS should have asked Petitioner to provide that information. *Id.* By denying Petitioner’s application before alerting her as to what information was missing and establishing a deadline for its submission, DFCS prematurely denied Petitioner’s application. *Id.*  Thus, Petitioner’s application was not correctly denied, as the appropriate procedure was not followed.

4.

Second, even if DFCS had been correct in denying Petitioner’s application for failure to provide verification, the promulgated rules of the Office of State Administrative Hearings (“OSAH”) take precedence over the unpublished *Medicaid Manual*. *Cf****.*** *Commissioner, Dep't of Human Resources v. Haggard*, 173 Ga. App. 676, 677 (1985). OSAH Rule 21(3) specifically states that hearings are “de novo in nature, and the evidence on the issues in a hearing shall not be limited to the evidence presented to or considered by the Referring Agency prior to its decision.” *See also Longleaf Energy Assocs., LLC v. Friends of the Chattahoochee, Inc.*, 298 Ga. App. 753, 768 (2009) (ALJ may not defer to the agency’s decision). Furthermore, the ALJ steps into the shoes of the referring agency and “may make any disposition of the case that could have been made by the Referring Agency.” OSAH Rule 21(1). Thus, the ALJ may reverse DFCS’s decision to deny Petitioner’s application without the need for her to reapply, because the initial denial is not yet final.[[3]](#footnote-3)

*b. The Department can deny Petitioner’s Medicaid application for reasons other than her income.*

5.

Petitioner contends that DFCS was required to consider all possible bases for denying her application before issuing the initial denial letter. She argues that because DFCS only addressed Petitioner’s income eligibility, it is estopped from looking into other eligibility factors, such as resources.

Petitioner’s argument is without merit. It would place an unreasonable burden on DFCS to require it—after it has already determined that an applicant is not eligible—to determine every other possible basis for a denial. Once DFCS determined Petitioner was over income, it had no obligation to then determine every other possible justification for denial. Thus, while this Court reverses DFCS’s determination that Petitioner is over income, upon continuing to review Petitioner’s application, it may determine that there are other, presently unknown, reasons for denying Petitioner’s application. DFCS can then deny Petitioner’s application on those grounds and she may, once again, appeal that decision to the Department of Human Services.

Finally, it is hoped that DFCS is in possession of most, if not all, documents needed to determine whether Petitioner is eligible for Medicaid in any month since her application was filed in October 2012. However, the administrative court realizes that DFCS will probably need verification of such items as bank account balances and newly-acquired resources. For this reason, DFCS can ask Petitioner to provide verification of any information needed to complete the application process.

1. **Decision**

**The Initial Decision of the Administrative Law Judge is as follows:**

1. Respondent’s action in denying Petitioner’s application for Nursing Home Medicaid for the months of October 2012 onward is **REVERSED.**
2. This matter is **REMANDED to DFCS** pursuant to OSAH Rule 29 to determine if Petitioner meets all eligibility factors for Medicaid for all months after the application, except for income. DFCS shall not require Petitioner to file a new application.
3. DFCS may require Petitioner to provide additional information needed to establish her Medicaid eligibility. If additional information is needed, DFCS shall provide Petitioner with written notice, such as a Verification Checklist, and allow at least ten (10) days for Petitioner to submit the necessary documentation. Petitioner may request an extension for good cause of the deadline for returning documentation.
4. Unless the deadline for providing documentation is extended for cause, DFCS shall determine Petitioner’s eligibility for Medicaid and issue written notice to Petitioner within thirty (30) days of this Order.
5. If Petitioner is not satisfied with DFCS’ determination, she may file a request for a fair hearing with the Department of Human Services, for referral to the Office of State Administrative Hearings.

**SO ORDERED this \_\_\_\_ day of June, 2013.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**M. PATRICK WOODARD, JR.**

**Administrative Law Judge**

1. A&A benefits are defined by the *Medicaid Manual* as “payment[s] made to veterans and certain dependents for medical and remedial care in their own home or a nursing home.” *Medicaid Manual* § 2418-1 [↑](#footnote-ref-1)
2. The documentation of Petitioner’s monthly income produced from Social Security and the VA differs slightly from the amounts stipulated by the parties at the hearing. The total RSDI and VA benefit other than A&A during 2012 was $1733.82. The difference is not material, as either puts her below the maximum monthly Medicaid cap. [↑](#footnote-ref-2)
3. The Department would be correct in requiring a new application in the event an applicant failed to exercise his or her appeal rights. [↑](#footnote-ref-3)