BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

J[redacted] D[redacted] Petitioner, v. DHS, FAMILY & CHILDREN SERVICES, Respondent.	:	Docket No.: OSAH-DFCS-NH-[redacted]Woodard Agency Reference No: 494090011

FILED
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AUG 1 2014

Hazel Jackson
Hazel Jackson, Legal Assistant

INITIAL DECISION

ORDER GRANTING PETITIONER'S MOTION FOR SUMMARY DETERMINATION

I. INTRODUCTION

Petitioner, a Medicaid recipient, requested a hearing to dispute Respondent's action in reducing the amount of Petitioner's Incurred Medical Expenses (IMEs), the institutional long-term care expenses that he incurred prior to Medicaid eligibility, by Petitioner's gross income during the pre-eligibility period, and deducting the reduced IME amount from his current patient liability.

Petitioner filed a Motion for Summary Determination with the Office of State Administrative Hearings on May 8, 2014, arguing that there is no genuine issue of material fact for determination and that he is therefore entitled to judgment as a matter of law. Respondent filed a response to Petitioner's motion on June 4, 2014.

The hearing in the above-docketed matter was originally scheduled for June 18, 2014. However, the matter was continued to consider Petitioner's Motion for Summary Determination. The undersigned, having considered the motions and exhibits of the parties and having reviewed other supporting material and the relevant law, concludes that, in calculating Petitioner's current patient liability, Respondent improperly reduced the deduction for IMEs contemplated by federal

law and the State Medicaid Plan. Accordingly, for the reasons indicated below, Petitioner's Motion for Summary Determination is **GRANTED.**

II. FINDINGS OF FACT

Petitioner's Previous Appeal

1.

Petitioner, J[redacted] D[redacted] was admitted to [redacted] ("[redacted]") on or about September 28, 2008 and has resided there through the date of this Order. *Petitioner's Motion for Summary Determination.*

2.

Petitioner applied for Medicaid on October 27, 2011. Petitioner's Medicaid application was denied for failure to include documentation of a properly-funded Qualified Income Trust (QIT). *Petitioner's Motion for Summary Determination.*

3.

Petitioner submitted a second Medicaid application on or about January 25, 2012. Respondent determined that the deficiencies in the October 27, 2011 application had been corrected and approved Petitioner for Long-term Care Medicaid beginning in December 2011 and ongoing. *Petitioner's Motion for Summary Determination.*

4.

On November 2, 2012, [redacted] submitted a Request for IMEs (Form 942) to Respondent, requesting that the medical expenses Petitioner incurred from June 2011 through November 2011 be deducted from his patient liability. *Petitioner's Motion for Summary Determination; Petitioner's Exhibit 3.*

5.

Although Respondent allowed deductions for the medical expenses Petitioner had incurred for October and November of 2011, it would not allow deductions for the medical expenses that Petitioner had incurred in July, August, and September 2011, the three months prior to Petitioner's October Application. *Petitioner's Motion for Summary Determination; Petitioner's Exhibit 3.*

6.

According to invoices from [redacted] that were attached to Petitioner's IME request forms, Petitioner incurred approximately $24,667.63 in bills during the disputed months: $8,215.00 in July, $8,502.63 in August, and $7,950.00 in September 2011. As detailed in the invoices, the charges included room and board calculated at a private pay rate of $255.00 per day as well as various fees. *Petitioner's Exhibit 3.*

7.

Petitioner disputed Respondent's determination that he was not owed deductions for medical expenses incurred in the months of July, August, and September 2011 and the matter was referred to the Office of State Administrative Hearings for adjudication (Docket No. OSAH-DFCS-NH-[redacted]-60-Malihi). The primary issue in that matter was the appropriate start date of the three-month "look-back" period for IMEs. *D[redacted]. Dep't Human Servs.*, OSAH-DFCS-NH-[redacted]-Malihi (February 16, 2014).

8.

After conducting an evidentiary hearing, the undersigned issued an Initial Decision on February 16, 2014, reversing Respondent's denial of IMEs and instructing Respondent to "calculate Petitioner's IME request at an amount equal to the Medicaid reimbursement rate in

accordance with the State Medicaid Plan." *D[redacted] v. Dep't of Human Servs.*, OSAH-DFCS-NH-[redacted] Malihi (February 16, 2014).

Calculation of Petitioner's Post-Eligibility Contribution to Care

9.

Respondent subsequently calculated Petitioner's monthly IMEs for July, August, and September 2011 in accordance with the Medicaid reimbursement rate ($165.01 per day):

- July 2011: $165.01 x 31 = $5,115.31 in IMEs
- August 2011: $165.01 x 31 = $5,115.31 in IMEs
- September 2011: $165.01 x 30 = $4,950.30 in IMEs

Petitioner's Exhibit 5; *Respondent's Exhibit A.*

10.

Respondent then added a "standard monthly deduction"[1] of $476.14 for each month:

- July 2011: $5,115.31 + $476.14 = $5,591.45
- August 2011: $5,115.31 + $476.14 = $5,591.45
- September 2011: $4,950.30 + $476.14 = $5,426.44

Petitioner's Exhibit 5; *Respondent's Exhibit A.*

11.

Respondent subtracted Petitioner's IMEs for each month from his gross monthly Social Security and Retirement Benefits income of $4,187.46 to arrive at an "IME Approved Allowance":

- July 2011: $4,187.46 – $5,591.45 = -$1,403.99
- August 2011: $4,187.46 – $5,591.45 = -$1,403.99
- September 2011: $4,187.46 – $5,426.44 = -$1,238.98

Petitioner's Exhibit 5; *Respondent's Exhibit A.*

[1] The standard monthly deduction included a "[Retirement Benefits] Federal tax deduction of $319.64, a Personal needs allowance" of $50.00, the Medicare Part B Premium of $96.50, and $10.00 for "Third Party Insurance." *Petitioner's Exhibit 5.*

12.

Respondent then subtracted the total amount of the IME Approved Allowance ($4,046.96) from Petitioner's gross monthly income to determine Petitioner's patient liability for March, April, and May 2014. By Respondent's calculations, Petitioner's patient liability was as follows for those months: $0 for March, $3,797.68 for April, and $3,922.32 for May. DCH's Right from the Start Long-Term Medicaid Section provided Petitioner with a detailed explanation of its calculation of his patient liability in a Notice dated February 27, 2014. *Petitioner's Exhibit 5*; *Respondent's Exhibit A*.

Petitioner's Current Appeal

13.

Petitioner requested a hearing upon receiving the above-described Notice from DCH, disputing the calculation of his patient liability. *Petitioner's Request for Hearing dated March 28, 2014.*

14.

On or about May 8, 2014, Petitioner filed a Motion for Summary Determination. Petitioner asserted in his Motion that, by deducting his income from the IMEs, Respondent had failed to award IMEs "at the Medicaid reimbursement rate" in contravention of the OSAH Decision, federal law, and the State Medicaid Plan. Petitioner cited 42 U.S.C. 1396a(r)(1)(A)(ii), 42 C.F.R. § 435.725, and the State Medicaid Plan in support of his argument. Because there was no dispute as to the Medicaid reimbursement rate, and Respondent had awarded IMEs at less than the Medicaid reimbursement rate, Petitioner submitted that there was no genuine issue of material fact and that he was therefore entitled to summary determination in his favor. *Petitioner's Motion for Summary Determination.*

15.

Respondent filed a Response to Petitioner's Motion for Summary Determination on or about June 4, 2014. In its Response, Respondent contended that it had calculated Petitioner's IMEs at the Medicaid reimbursement rate but that it was thereafter obligated to deduct Petitioner's gross income pursuant to federal law and the State Plan. Respondent cited the "post-eligibility financial requirements for the categorically needy" prescribed in the Code of Federal Regulations (42 C.F.R. 435.725) in support of its argument that it was required to deduct Petitioner's income from the medical expenses that he incurred during July, August, and September 2011. *Respondent's Response to Petitioner's Motion for Summary Determination dated June 4, 2014.*

16.

Petitioner submitted a Reply on June 13, 2014, asserting that the post-eligibility criteria expressed in the Code of Federal Regulations contained no authorization or mandate for Respondent to reduce the amount of a resident's IMEs by the resident's gross income. Rather, Petitioner argued, the regulations cited by Respondent governed *post-eligibility* treatment of income and did not support a reduction of IMEs incurred *prior* to Medicaid eligibility. Petitioner reiterated his position that Respondent was required to calculate IMEs pursuant to the reasonable limitations set forth in the State Plan approved by CMS, that is, "at an amount equal to the Medicaid reimbursement rate." Deduction of Petitioner's IMEs at the Medicaid reimbursement rate, Petitioner argued, comported with Congress's intent to permit Medicaid recipients to use their income to pay the incurred expense while also paying the ongoing nursing home bill. *Petitioner's Reply in Support of Motion for Summary Determination.*

III. CONCLUSIONS OF LAW

1.

Summary determination in a contested case before the Office of State Administrative Hearings is governed by OSAH Rule 15, which provides, in relevant part:

> A party may move, based on supporting affidavits or other probative evidence, for summary determination in its favor on any of the issues being adjudicated on the basis that there is no genuine issue of material fact for determination.

GA. COMP. R. & REGS. 616-1-2-.15(1). On a motion for summary determination, the moving party must demonstrate that there is no genuine issue of material fact, such that the moving party "is entitled to a judgment as a matter of law on the facts established." *Pirkle v. Envtl. Prot. Div., Dep't of Natural Res.*, OSAH-BNR-DS-0417001-58-Walker-Russell, 2004 Ga. ENV. LEXIS 73, at *6-7 (Oct. 21, 2004) (citing *Porter v. Felker*, 261 Ga. 421 (1991)); *see generally Piedmont Healthcare, Inc. v. Ga. Dep't of Human Res.*, 282 Ga. App. 302, 304-05 (2006) (noting that summary determination is "similar to a summary judgment" and elaborating that an administrative law judge "is not required to hold a hearing" on issues properly resolved by summary adjudication).

Further, pursuant to OSAH Rule 15:

> When a motion for summary determination is made and supported as provided in this Rule, a party opposing the motion may not rest upon mere allegations or denials, but must show, by affidavit or other probative evidence, that there is a genuine issue of material fact for determination in the hearing.

GA. COMP. R. & REGS. 616-1-2-.15(3); *see Lockhart v. Dir., Envtl. Prot. Div., Dep't of Natural Res.*, OSAH-BNR-AE-0724829-33-RW, 2007 Ga. ENV LEXIS 15, at *3 (June 13, 2007) (citing *Leonaitis v. State Farm Mutual Auto Ins. Co.*, 186 Ga. App. 854 (1988)).

2.

In the present case, Petitioner contends that, because the law requires IMEs to be allowed as a deduction at an amount equal to the Medicaid reimbursement rate, and Respondent does not dispute that it allowed IMEs as a deduction at an amount *less* than the Medicaid reimbursement rate, there is no longer a genuine dispute of material fact for determination.

3.

Federal law requires that a state agency "reduce its payment to an institution, for services provided to an [institutionalized] individual . . . by the amount that remains" after applying certain specified deductions to that individual's income. 42 U.S.C. § 1396a (2014); 42 C.F.R. § 435.725(a). "In reducing its payment to the institution, the agency must deduct . . . from the individual's total income . . . [incurred medical expenses] subject to reasonable limits the agency may establish on amounts of these expenses." 42 C.F.R. § 435.725(c)(4)(ii); *see also* 42 U.S.C. § 1396a(r)(1)(A)(ii). Accordingly, medical expenses, including institutional long-term care medical expenses that an individual incurs prior to Medicaid eligibility, can be deducted from that individual's patient liability. *See* STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (hereinafter STATE MEDICAID PLAN), Supplement 3 to Attachment 2.6-A; *see, e.g., Miller v. Olszewski*, No. 09-13683, 2009 U.S. Dist. LEXIS 118984, *9 (E.D. Mich. Dec. 21, 2009) ("Thus, the amount the recipient must contribute to the cost of long-term-care—the recipient's post-eligibility contribution to care—is dependent upon the amount of his income less prescribed deductions.").

4.

State agencies may impose "reasonable limits . . . on amounts of [incurred medical] expenses." 42 C.F.R. § 435.725(c)(4)(ii); STATE MEDICAID PLAN, Supplement 3 to Attachment

2.6-A. These limitations must be incorporated into the State Medicaid Plan and approved by the Center for Medicare and Medicaid Services (CMS). *Id.; Md. Dept. of Health and Mental Hygiene v. CMS*, 542 F.3d 424, 435 (4th Cir. 2008).

5.

The limitations that DCH may put on IMEs are expressed in Supplement 3 to Attachment 2.6-A in the State Medicaid Plan, which provides, in pertinent part:

> Effective April 1, 2009, institutional long-term care medical expenses incurred more than three months prior to the month of application for Medicaid are disallowed as a deduction. Institutional long-term care medical expenses incurred within three months prior to the month of application *may be allowed as a deduction at an amount equal to the Medicaid reimbursement rate.*

STATE PLAN, Supplement 3 to Attachment 2.6-A (emphasis added).

The language of the provision is unambiguous. It limits the amount of institutional long-term care expenses that may be deducted from a patient's income by allowing the state agency to disallow such expenses if they are incurred by the individual more than three months prior to the month of application. The provision also allows the state agency to limit deductions for such expenses incurred *within* three months of the month of the individual's application by calculating them at the Medicaid reimbursement rate. Use of the word "may" in the provision is not a grant of discretion to the State agency with regard to the amount of the deduction. When read in context, it is clear that the word "may" in the provision permits the state agency to grant IMEs as a deduction at the Medicaid reimbursement rate, rather than grant the deduction for the face value of the expense. In reading the provision, one must consider that it is a grant of a narrow limitation of the very broad federal mandate that state agencies deduct an individual's IMEs from income in determining the individual's prospective liability for care. 42 C.F.R. § 435.725(c)(4)(ii) (2014).

Respondent contends that it is in compliance with federal law and the State Plan in reducing Petitioner's *pre-eligibility* IMEs by his *pre-eligibility* income. Respondent cites federal regulations governing "Post-eligibility treatment of income of institutionalized individuals" in support of its contention that it must reduce its payment to institutions for services by the individual's income. 42 C.F.R. § 435.725 (2014). However, as Petitioner noted in his Motion for Summary Determination and subsequent Reply in Support, the federal law cited by Respondent governs post-eligibility determinations of patient liability and does not stand for the proposition that state agencies must, or even may, include the individual's income in calculation of *IMEs*. *See id.* Indeed, as discussed *supra*, the post-eligibility regulations require state agencies to deduct IMEs and specify that states may limit such deductions only through "reasonable limitations." 42 C.F.R. § 435.725(c)(4)(ii) (2014). The reasonable limitations referred to in the post-eligibility regulations are those expressed in the State Medicaid Plan, which requires that Respondent deduct IMEs "at an amount equal to the Medicaid reimbursement rate." Accordingly, by deducting IMEs from patient liability at an amount *less* than the Medicaid reimbursement rate, Respondent has exceeded the parameters of the reasonable limitation expressed in the State Plan and has impermissibly limited the deduction from patient liability in violation of the governing regulations. Respondent has not followed the clear language of the State Plan, which the state agency to "*allow*[]. . . *deduction*[s] at an amount equal to the Medicaid reimbursement rate." STATE PLAN, Supplement 3 to Attachment 2.6-A (emphasis added). The state agency must *allow* the individual such deductions at the Medicaid reimbursement rate, and not simply calculate them according to the Medicaid reimbursement rate. *See id.*

IV. DECISION

IT IS HEREBY ORDERED that Petitioner's Motion for Summary Determination is **GRANTED**. Accordingly, Respondent's decision to reduce the amount of Petitioner's IME deduction by his income is **REVERSED**.

Respondent is hereby instructed to calculate the institutional long-term care expenses Petitioner incurred at Fountainview prior to his October 2011 Medicaid application, "at an amount equal to the Medicaid reimbursement rate" as follows:

July 2011:	31 x $165.01 = $5,115.31
August 2011:	31 x $165.01 = $5,115.31
September 2011:	30 x $165.01 = $4,950.30

These are the appropriate amounts to be deducted from Petitioner's income for determination of his current patient liability.

SO ORDERED, this 1st day of August, 2014.

M. PATRICK WOODARD
Administrative Law Judge