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

PETITIONER,

Vs.

APPEAL NO. 11F-01322

CASE NO. 1326446631

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 02 Franklin
UNIT: 88510

RESPONDENT.
_________________________________/

FILED
May 16, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by telephone conference call in the above-referenced matter on April 11, 2011 at 9:30 a.m.

APPEARANCES

For the Petitioner: , Esq.

For the Respondent: Rebecca Kapusta, Esq.
Assistant Regional Counsel
2383 Phillips Road
Tallahassee, FL 32308

STATEMENT OF ISSUE

Whether the exclusion of expenses for nursing facility services rendered prior to Medicaid Eligibility as an uncovered medical expense deduction in the calculation of patient responsibility is appropriate based on Federal and State Law.

PRELIMINARY STATEMENT

By notice dated October 25, 2010, the petitioner and his wife were notified that their applications for Institutional Care Program (ICP) Benefits were approved for the retroactive months of December 2009 through April 2010. The petitioner was previously notified of eligibility for the ICP program beginning May 2010. On December 8, 2010, the petitioner timely appealed the patient responsibility assigned by the Department.

The petitioners submitted into evidence Petitioner's Composite Exhibit 1.

Testifying on behalf of the Respondent was Annie Jo Martin, Operations Management Consultant. Submitted into evidence was Respondent's Composite Exhibit 1.

A pre-hearing conference was held on March 31, 2011 with the representatives for both parties to address a request for a continuance. The hearing was continued until April 11, 2011. The record was held open for 10 days or until April 21, 2011 for the submission of Memorandums of Law.

FINDINGS OF FACT

Both parties have stipulated to the following facts which are not in dispute.

1. The petitioner and his wife have resided in a skilled nursing facility since at least June 24, 2009.

2. The petitioner and his wife applied for ICP and Medicaid on December 2, 2009 and in March 2010 and were originally denied due to excess assets.

2. Eligibility for the ICP and Medicaid programs was subsequently established retroactively for the months of December 1, 2009 and ongoing. The petitioner and his wife did not meet ICP and SSI-Related Medicaid eligibility criteria for the months of June 24, 2009 through November 30, 2009 and are responsible for room and board expenses of $9,336.68 and $9,661.60 respectively.

3. The petitioners' representative is requesting modification of the patient responsibility. The petitioners are requesting that the outstanding uncovered nursing facility bills incurred prior to establishment of Medicaid eligibility be allowed as a medical deduction and applied toward a reduction in the patient responsibility.

4. The record was held open so that both parties could submit Memorandums of Law to support their positions. These were received and given due consideration.

CONCLUSIONS OF LAW

5. 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.

6. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

7. In accordance with Fla. Admin. Code § 65-2.060(1) the burden of proof was assigned to the petitioner.

8. The issue before the undersigned is whether expenses for nursing facility services incurred prior to Medicaid eligibility may be deducted as an uncovered medical expense deduction and therefore, reduce the patient responsibility.

9. The petitioners' position is that the Department's "failure to decrease [redacted] [redacted] and [redacted] patient responsibility to account for outstanding uncovered skilled nursing facility costs" was in error based on the Department's reliance on Section 2640.0125.01 of the Florida Economic Self Sufficiency Manual. The petitioners' argument is that Florida's Medicaid program is authorized under title XIX of the Social Security Act, which states that Florida must comply with its eligibility requirements.

10. The petitioner is relying on Section 1902(a)(A) of the Act, 42 U.S.C. §1396a(r)(1)(A)(ii) that states:

> (r) Disregarding payments for certain medical expenses by institutionalized individuals
>
> (1)(A) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account 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, and
>
> (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

11. The petitioners' representative argued that the Department's policy set forth in the Department's Economic Self-Sufficiency policy manual at Section 2640.0125.01 does not allow a medical expense deduction to be deducted from the individual's income available for patient responsibility when it is for skilled nursing facility medical expenses incurred prior to the establishment of eligibility for Medicaid. Under Federal Law set forth in 42 U.S.C. 1396a(r)(1)(A) the petitioner's representative argued that the State does not have the right to restrict reduction of patient responsibility in this way unless the State plan allows for such reduction.

12. The petitioner's representative argued that the State of Florida is required to submit a State Medicaid plan for approval by Centers for Medicare and Medicaid Services (CMS) and to administer its Medicaid program in accordance with that plan. The State plan is the mechanism through which the State can place reasonable limits on the amount of expenses it deducts from the patient responsibility amount. The petitioners' representative argued that Florida's plan does not reveal a request for such a restriction.

13. Florida's State plan at 2.6A- supplement 3 states in part:

> 1924 of the Act
> 435.725
> 435.733
> 435.832
> 2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:
>
> Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons.

a. Aged, blind, disabled:
Individuals $--35
Couples $--70…

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:
(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6A…

Post-Eligibility Treatment of Institutionalized Individuals' Incomes
Effective January 1, 2004, the following policy will be applied in considering medical expense deductions for institutional care cases in the post-eligibility treatment of income in accordance with 42 CFR 435.725. The state will recognize as an uncovered expense and deduct from an institutional resident's income any premium, deductible, or coinsurance charges for health insurance coverage. The following reasonable limits will be placed on other incurred medical expense deductions for residents of medical institutions in the post-eligibility treatment of income:
1. The service or item claimed as a deduction from the resident's income must be a medical/remedial care service recognized under state law.
2. Only medically necessary services and items will be allowed as deductions.
3. Services and items covered and paid for under the Medicaid State Plan will not be allowed as deductions.
4. Services and items covered by and paid for under the Medicaid nursing or other facility per diem will not be allowed as a medical expense deduction.
5. For medically necessary services and items not covered by the Medicaid State Plan, the actual paid amount will be used as the deduction, subject to the following limit: the highest of a payment/fee recognized by Medicare, commercial payers or any other third party payer for the same or similar item.
6. Other resident health insurance policies will be treated as first payer and the beneficiary will have to demonstrate that other insurance has not/will not cover the claimed expense.

14. Federal regulations at Title 42 Section 435.725 C.F.R., states in pertinent part:

§ 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,…

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.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under §435.230; or

(iii) The amount of the medically needy income standard for one person established under §435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

> (ii) Be adjusted for the number of family members living in the home; and
> (iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under §435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.
> (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.

15. In accordance with 42 C.F.R. 435.725, Fla. Admin. Code 65A-1.7141 pertaining to SSI-Related Medicaid Post Eligibility Treatment of Income was promulgated.

16. Section 65A-1.714 SSI-Related Medicaid Post eligibility Treatment of Income, states in relevant part:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance….
> (g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.
> 1. The medical/remedial care service or item must meet all the following criteria:

a. Be recognized under state law;
b. Be medically necessary;
c. Not be a Medicaid compensable expense; and
d. Not be covered by the facility or provider per diem….

3. Expenses for services or items received prior to the first month of Medicaid eligibility can only be used in the initial projection of medical expenses if the service or item was provided during the three month period prior to the month of application and it is anticipated that the expense for the service or item will recur in the initial projection period.

4. For the initial projection period, the department will allow a deduction for the anticipated amount of uncovered medical expenses incurred during the three month period prior to the date of application, **and that are recurring (reasonably anticipated to occur) expenses** in the initial projection period. (emphasis added)

5. Actual incurred and recognized expenses will be deducted in each of the three months prior to the Medicaid application month when an applicant requests three months prior Medicaid coverage and is eligible in the prior month(s).

17. The above Florida rule allows for a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility and as authorized by the Medicaid State Plan. This rule also explains that the Department will allow a deduction for the anticipated amount of uncovered medical expenses incurred during the three month period prior to the date of application that are recurring (reasonably anticipated to occur) expenses in the initial projection period.

18. The Department's program policy manual, 165-22, Section 2640.0125.01 sets forth the types and amounts of medical expenses that may be deducted from an individual's income available for patient responsibility:

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 coonsurance 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:
> … 3. The medical expense is for nursing facility services, including those incurred during a penalty period.
> Expenses for services received prior to the first month of Medicaid eligibility can only be used in the initial projection if the service was incurred in the three months prior to the month of application **and only if the service is anticipated to recur.** (emphasis added)

19. The above Florida Administrative Code and the Department's policy manual directs that the Department only use the past medical medical expenses as a projection or estimation of ***current bills to recur***. The past bills incurred for nursing facility services are not recurring expenses for the months of ICP Medicaid eligibility.

20. The respondent argued that the above authorities allow for reasonable limitations to be set by each state on amount of expenses. Florida's State plan, approved by CMS, excludes consideration for payments for those service to be paid for by Medicaid. The Department applies a literal interpretation of the federal statute and regulation which state "there should be taken into account amounts for incurred expenses for medical or remedial care recognized under State law but not covered under the State Plan." Further, it is the Department's argument that the Department's exclusion of expenses for nursing facility services rendered prior to Medicaid eligibility as an uncovered medical expense deduction in the calculation of patient responsibilty is appropriate under State and Federal Law.

21. After a review of the federal and state regulations and the Florida State plan, the undersigned can find no authority that allows for nursing facility services incurred prior to eligibility for Medicaid to be deducted as an ongoing medical expense in the

calculation of the ongoing patient responsibility. The federal and state authorities specifically state that deductions may be used for health insurance payments, premiums, deductibles and coinsurance charges. When the patient responsibility amount is reduced by the amount of an insurance premium the ICP eligible individual makes, the purpose is to allow that individual to have enough income to make that payment that is recurring, thereby typically reducing the amount of money Medicaid pays for the individual's medical expenses. There is no language in the federal or state authorities that allow counting the past bill that is not recurring as a medical expense for the ongoing patient responsiblity. The undersigned concludes that the Department determined the petitioners were not eligible for June through November 2009 and if the ongoing patient responsibilty was reduced due to those bills, Medicaid would be paying a larger share of the petitioners' ongoing care in the facility due to a past period of time when petitioners were determined to be ineligible for ICP Medicaid. The undersigned concludes that the Department appropriately excluded expenses for nursing facility services rendered prior to Medicaid eligibility as an uncovered medical expense deduction in the calculation of patient responsibility; these past bills are not recurring bills and are not allowed in the rules.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this ______ day of ____________________, 2011,

in Tallahassee, Florida.

____
Linda Garton
Hearing Officer
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