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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 11F-04586

CASE NO. 1303490579

FILED
Jul 29, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

FINAL ORDER

Pursuant to an agreement between the parties, the undersigned convened a pre-conference administrative hearing by telephone in the above-referenced matter on July 12, 2011 at 12:07 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: [redacted]

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 Institutional Care Program (ICP) patient responsibility is appropriate based on Federal and State Law.

PRELIMINARY STATEMENT

While on record, both parties agreed to waive a final hearing and submit document exhibits into evidence, opposing memorandums of law, and a joint stipulation of facts. Thereafter, both parties submitted their exhibits into the record. On July 14, 2011, a Joint Stipulation of Summary of Facts Supported by Documents in Evidence was received and is now adopted in the Findings of Facts as paragraphs numbered one through six. On July 14, 2011, petitioner's Memorandum of Law was received.

Petitioner submitted into evidence Petitioner's Composite Exhibit 1 which includes the following documents pages 1 through 22: Notice of Hearing, Acknowledgement of Hearing Request, Submission of medical bills to Florida Department of Children and Families, Notice of Case Action June 16, 2011, Request for unpaid medical bills, Request to use nursing home bill as unmet medical expenses, Notice of Application Disposition, Notice of Case Action March 15, 2011, and Supporting documentation and request for adjustment of patient responsibility (submitted with application).

Respondent submitted into evidence Respondent's Composite Exhibit 1 which includes the following documents pages 1 through 8: Hearing Appointment letter, Calculation of Benefits from the Department's Program Policy Manual, Payment

Reconciliation Summary, Notice of Case Action dated June 16, 2011 and an email regarding scheduling.

The record was held open until close of July 14, 2011 for the submission of Memorandums of Law and the Joint Stipulation of Facts.

FINDINGS OF FACT

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

1. [redacted] is now and has been a resident at [redacted] a skilled nursing facility (the "Facility" or [redacted]) in Tallahassee, Florida since April 2009. She is a widow, and before moving to the Facility she lived with her granddaughter. [redacted] is [redacted] legal guardian.

2. The Facility applied several times for long term care Medicaid benefits under Florida's Institutional Care Program ("ICP") beginning in February, 2010, but these applications were denied for various reasons, primarily because of lack of documentation required by the Department of Children and Families ("DCF" or the "Department").

3. An application for ICP benefits was filed online on February 8, 2011, sought retroactive coverage effective February 2010. The application also submitted the Heritage bill for care predating February 2010 as pre-eligibility unmet medical expenses ("PEME", "UME" or "UMED") and asked for [redacted] patient responsibility amount to be reduced by these amounts[.]

4. On March 14, 2011, the Department issued a Notice of Application Disposition in which it approved ICP benefits retroactively to February 2010. Under the comments/remarks section of this Notice, the Department stated: "We cannot adjust the

pat [sic] responsibility amount for the UMED that was requested due to this is not an allowable expense per state policy 2640.0125.01". The Notice of Case Action related to this approval was issued on March 15, 2011. (Subsequent notices of case action have been issued but do not change or affect the relevant facts to this proceeding).

5. Petitioner filed a timely Request for Hearing on the specific issue of failing to budget, i.e., deduct, the unmet medical expenses from [redacted] patient responsibility amount. The Department acknowledged the Request for Hearing, assigned a Hearing Officer and set the hearing for July 15, 2011.

6. A pre-hearing conference was held on July 12, 2011. The parties agreed to the admission of evidence and to stipulate to these facts, then submit the issue to the Hearing Officer on memoranda of law.

CONCLUSIONS OF LAW

7. 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.

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

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

10. 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, in the ICP eligibility determination, which results in a reduced patient responsibility.

11. Petitioner argues "that Respondent's failure to decrease [redacted] patient responsibilities to account for outstanding uncovered skilled nursing facility costs was in error" because "Section 1902(r)(1)(A) of the Act, 42 U.S.C. §1396a(r)(1)(A)(iii) requires that states allow a reduction in patient responsibility to account for '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.'"

12. Petitioner argues in order for the State to place reasonable limits on the types of expenses deducted from patient responsibility, it would require the State Medicaid plan to include said reasonable limits and be approved by Centers for Medicare and Medicaid Services (CMS).

13. Petitioner argues Florida's State Plan does not contain such restriction on nursing home expenses, and therefore petitioner can deduct from her patient responsibility the nursing home necessary medical expenses incurred prior to Medicaid eligibility.

14. Petitioner relies on Section 1902(a)(A) of the Act, 42 U.S.C. §1396a(r)(1)(A)(ii) which 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.

15. 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.

16. Federal regulations at 42 C.F.R. § 435.725, 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.

17. Fla. Admin. Code § 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).

18. 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.

19. According to above stated Federal Regulation, respondent may establish reasonable limits to expense deductions based on necessary medical or remedial care recognized under State law for expenses not covered under the State's Medicaid plan. The undersigned concludes that Florida Administrative Code § 65A-1.714 properly establishes these reasonable limits for necessary medical or remedial care expense deductions under direction of 42 C.F.R § 435.725(c)(4).

20. The Department's Program Policy Manual, 165-22, § 2640.0125.01 further 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]

21. The above Florida Administrative Code and the Department's Policy Manual directs the Department to only use the past medical expenses that are reasonably anticipated to reoccur in the initial projection period. The past bills incurred

for nursing facility services are not recurring expenses for the months of ICP Medicaid eligibility.

22. The undersigned concludes that the Department properly excluded expenses for nursing facility services rendered prior to Medicaid eligibility as an uncovered medical expense deduction in the calculation of patient responsibility.

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.

_____

Nathan Koch
Hearing Officer
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