State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

JOHN R. GUHL
Director

FAIR HEARING UNIT

609-588-2656

April 12, 2010

Lauren Marinaro, Esq.
Fink, Rosner
1093 Raritan Rd.
P.O. Box 858
Clark, NJ 07066

RE: **FINAL AGENCY DECISION**
Elizabeth Ravese v. DMAHS &
Union County Board of Social
Services
OAL Dkt. No. HMA 09910-09

Dear Ms. Marinaro:

Enclosed is the Final Agency Decision rendered in the above-captioned matter.

If you are dissatisfied with the decision, you have the right to seek judicial review by the Appellate Division, Superior Court of New Jersey, Richard J. Hughes Complex, P.O. Box 006, Trenton, New Jersey 08625. A request for judicial review must be initiated within 45 days from the date of receipt of the decision.

Yours very truly,

Robert M. Liwacz, Esq.
Office of Legal and Regulatory
Liaison/DMAHS

Enclosure
c: Barbara Vanderheyden

State of New Jersey
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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

E.R.,

PETITIONER,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND DEPARTMENT OF HEALTH AND SENIOR SERVICES,

RESPONDENTS.

ADMINISTRATIVE ACTION

FINAL AGENCY DECISION

OAL DKT. NO. HMA 9910-09

As Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision, the OAL case file, and the documents in evidence. Petitioner and Respondent filed exceptions in this matter. Procedurally, the time period for the Agency Head to file a Final Agency Decision in this matter is April 12, 2010, in accordance with N.J.S.A. 52:14B-10 which requires an Agency Head to adopt, reject, or modify the Initial Decision within 45 days of receipt. The Initial Decision in this matter was received on February 24, 2010.

The issue here concerns Petitioner's request to have her post-eligibility income applied to medical bills she failed to pay before her eligibility date of July 1, 2008. The $4,000 in bills are for "Supportive Living Plus" provided at Atria, an assisted living facility, by a home health aide or similarly licensed individual. In April 2009 Petitioner requested that the unpaid bills be paid for out of her income under the post-eligibility treatment of income.

At the time of Petitioner's request, New Jersey had not limited the amounts that can be deducted pursuant to 42 U.S.C. sec 1396(r)(1)(A). After reviewing the record and the exceptions filed herewith, I agree with the ALJ and ORDER that Petitioner's post -eligibility income be reduced beginning May 1, 2010 until such time the deductions equal the unpaid $4,000 bill. As Petitioner is currently residing in a nursing facility, the Department of Health and Senior Services shall see that this deduction is made. It shall be Petitioner's responsibility to remit the payment to Atria. No other deductions for unpaid bills shall be permitted.

THEREFORE, it is on this 12th day of APRIL 2010,

ORDERED:

That the Initial Decision in this matter is hereby ADOPTED; and

That beginning May 1, 2010, and until such time the amount of $4,000 is reached; there shall be deduction from Petitioner's post eligibility income.

John R. Guhl, Director
Division of Medical Assistance
and Health Services

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. HMA 9910-09

E. R.,

Petitioner,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES and DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,

Respondent.

Lauren S. Marinaro, Esq. and Power of Attorney petitioner, appearing pursuant to N.J.A.C. 1:10B-5.1

Barbara Vanderheyden, Director of Care Management for respondent, appearing pursuant to N.J.A.C. 1:1-5.4(a)(2)

Record Closed: October 16, 2009 Decided: February 24, 2010

BEFORE **IRENE JONES**, ALJ:

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Petitioner, E.R., appeals the denial by the Union County Division on Aging ("UCDA" or "respondent") of a cost share deduction. Petitioner seeks to apply a portion of her monthly income to an unpaid assisted living balance incurred at her assisted

living residence prior to her Medicaid eligibility date of July 1, 2008. On June 23, 2009, respondent denied petitioner's request because it alleges that the costs for services are not permissible cost share deductions. Petitioner, timely requested a fair hearing and the Division of Medical Assistance and Health Services (DMAHS) transmitted the matter to the Office of Administrative Law (OAL) for hearing as a contested case on September 9, 2009.

Prior to the hearing, the parties submitted a Stipulation of Facts on October 15, 2009. Petitioner filed a letter brief dated October 5, 2009 and a supplemental letter brief on October 15, 2009. The hearing was held and concluded on October 16, 2009. Petitioner subsequently submitted a letter dated January 8, 2010. After the conclusion of testimony and oral argument of counsel, the record was closed on October 16, 2009.

ISSUE PRESENTED

At issue is whether or not the services provided by petitioner's assisted living facility constitute medical or remedial services and therefore, subject to the cost-share deduction to pay back the debt incurred for these services.

FINDINGS OF FACT

The parties stipulated to various facts as set forth in Exhibit P-A.[1]

At the hearing, testimony was presented by Maria Johnson, the Community Business Director of Atria, Gregory Papazian, the Program Manager with the New Jersey Department of Health and Senior Services (DHSS), and Alice Obelleiro, a County Liaison with Department of Health and Senior Services ("DHSS"). Based upon a review of the parties' stipulations and the documentation admitted at the hearing and the testimony presented, I **FIND** the following undisputed **FACTS**:

[1] P-A refers to the Joint "Stipulation of Facts. All other P exhibits are the petitioner's exhibits. Respondent's exhibits are designated with a R.)

Petitioner, a resident of Atria Assisted Living facility (Atria), in Cranford, New Jersey, at all times relevant to this proceeding,[2] has been receiving Medicaid waiver services at the above address since July 1, 2008. Petitioner's waiver services transitioned to the Global Options for Long-Term Care waiver program as of January 1, 2009.

Prior to Medicaid eligibility, petitioner incurred a debt for care services received at Atria that is still outstanding in the amount of $4000.00. (P-A). Maria Johnson ("Johnson") Atria's Community Business Director testified regarding petitioner's outstanding charges prior to receiving Medicaid. (P-E). Johnson stated that Atria rates include the basic rent for the room and then the cost of care is added on top of that in the present matter, the cost is $1000.00 per month for "Supportive Living Plus" services. The services include assistance with showering, dressing, grooming and medication management. These services are provided either by a Home Health Aide, licensed by the New Jersey Department of Community Affairs, or certified Nurse Aides and Medication Aides licensed by DHSS. The specific care program for each Atria resident is determined by the nurse's assessment according to the resident's individual needs. In the present matter, the nurse determined that petitioner was not capable of showering, dressing, grooming and managing her medication on her own.

On April 27, 2009, petitioner requested from the respondent a cost-share deduction for the supportive living plus services debt. On June 23, 2009, the respondent denied the request because it concluded that based on Program Instruction # GA PU-2008-03, costs for services provided by Atria prior to Waiver enrollment, are not permissible cost share deductions. The instruction came from the DHSS. (P-C). At the time of the request, petitioner's cost share was $43.00. (P-D). Briefly, the DHSS is the State operating agency for the Medicaid waiver program. It is responsible for applying to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on behalf of the New Jersey Division of Medical

[2] On or about January 8, 2010, Petitioner, a Medicaid resident of Atria, had a medical episode that led to hospitalization and subsequent Medicare-paid rehabilitation at Delaire Nursing and Rehabilitation Center in Linden. After that period of rehabilitation, she was evaluated by Atria staff for return to her residence there but it was determined that she needed a higher level of care than Atria could provide. Thus, petitioner is now a Medicaid-paying long-term care resident of Delaire.

Assistance and Health Services (DMAHS) to administer all long-term care services in New Jersey. [3]DHSS formulates policy which is then operationalized by the care managers and care coordinators in the counties, such as Barbara Vanderheyden (Vanderheyden).

DHSS is responsible to determine clinical Medicaid eligibility and DMAHS determines financial Medicaid eligibility. Once DMAHS determines financial Medicaid eligibility, the file is then administered to a case manager to manage that case. DHSS is responsible to determine, on a yearly basis, the room and board rate and the personal needs allowance; these figures are deducted on the cost-share worksheet (CSW). Deductions are also made for the Medicare premium, supplemental insurance premiums if necessary and any outstanding medical bills, such as prescriptions.

Regarding Program Instruction GQ PI-200803, upon which the denial was made, The State the Program Manager, Gregory Papazian, (Papazian,) explained that program instructions are policies developed by DHSS for the administration of the waiver program. GQ PI-200803 provides that "if an amount for services provided to the participant by the facility/agency prior to Waiver enrollment has been included as a deduction on the CSW, it must be deleted. It is not a permissible deduction. The CSW must be revised." (P-C). This represented a limitation on these sorts of deductions in the CSW. However, in its waiver application (P-H), the State chose not to establish limitations for deductions regarding incurred medical or remedial care expenses not subject to payment by a third party. DHSS's waiver application to CMS to operate the assisted living waiver program was approved by The Center for Medicare and Medicaid Services ("CMS") as operational. Papazian implicitly acknowledged that the instant debt is for remedial services because he conceded that had petitioner been found eligible for Medicaid as of March 2008, Medicaid would have covered these care services at Atria for the four months in question and this issue would be moot.

The County Liaison, Alice Obelleiro (Obelleiro) testified that after all deductions are made on the CSW, any available income left over is used as a cost-share paid to

[3] Once DMAHS determines financial Medicaid eligibility, the file is then administered to

the facility to offset the amount the facility bills Medicaid. If there is available income and the individual had an allowable medical or remedial deduction, that person would be allowed to apply the excess income toward that medical deduction. In the present matter, petitioner's monthly cost share was $43, which was given to Atria to offset the amount Atria bills Medicaid. Further, she believes that the Supportive Living Services do not constitute medical or remedial services because the specific services are part of the global services and should not be broken out of a person's care at a nursing home and billed separately.

LEGAL DISCUSSION AND CONCLUSIONS

Petitioner is seeking a post-eligibility income deduction. Petitioner was charged for care services, "Supportive Living Plus," which were provided by a combination of employees holding State licenses. Petitioner contends that the services received and billed were "remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law."

Respondent asserts that had E.R. been determined financially eligible for Medicaid back in March 2008, Medicaid would have covered the disputed $4000 Atria debt. However, petitioner began the application process in February 2008, but because of some problems with the financial spend down she was unable to get under the $2000.00 statutory income limit before July 1, 2008, petitioner's effective eligibility date.

The CMS-approved Global Options waiver, 42 U.S.C.A. 1396r(1)(A), applies to Medicaid waiver programs. 42 U.S.C.A. 1396a(r)(1)(A) provides that

> for purposes of a waiver . . . , 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, . . . 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--

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a case manager to manage that case.

> (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 title [42 U.S.C.A. §§ 1396 et seq.], subject to reasonable limits the State may establish on the amount of these expenses.
>
> [42 U.S.C.A. § 1396a(r)(1)(A).]

It is generally well established that CMS's interpretation, even when not formalized by adoption of an administrative regulation, is "entitled to respectful consideration and deference." F.K. v. Div. of Med. Assistance and Health Serv., 374 N.J. Super. 126, 142 (App. Div. 2005). With regard to Medicaid, due to the extraordinary complexity of the Medicaid Act, Congress delegated to the CMS broad authority to "stand[ ] in the shoes of Congress" and interpret the Medicaid statute, U.S. v. Mead Corp., 533 U.S. 218, 229-30, 121 S. Ct. 2164, 150 L. Ed. 2d 292 (2001). CMS ha[s] interpreted the phrase "not covered under the State plan" to refer to services a recipient obtained prior to Medicaid eligibility, i.e., any "medical services for which Medicaid does not pay, and ha[s] required states to deduct expenses for such services consistently in both the spend down and post-eligibility processes." Md. Dep't of Health & Mental Hygiene v CMS, 542 F.3d 424, 435 (4th Cir. 2008). CMS's traditional interpretation of the phrase was deemed a "reasonable" interpretation of 42 U.S.C.A. § 1396a(r)(1)(A) "in light of Congress' expressed policy permitting Medicaid recipients to pay down medical expenses incurred prior to Medicaid eligibility, as well as the clear purpose of Medicaid statute to provide medical services to low-income recipients." Id. at 436.

In promulgating its post-eligibility income regulations CMS defined "Medicaid or other remedial care provided by licensed practitioners" as "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." 42 C.F.R. 440.60(a). This definition is broad in nature.

I **FIND** that the "Supportive Living Plus" the care services that petitioner received were provided by licensed personnel to remedy her difficulties with certain activities of daily living that would otherwise prevent her from living in a community setting. While 42 U.S.C.A. § 1396a(r)(1)(A) permits states to impose "reasonable limits" on deductions of incurred medical expenses, New Jersey's state plan, including its Global Options waiver, lists no reasonable limits on what kind of remedial care can be paid down through a post-eligibility income deduction. Therefore, I **FIND** that the care services petitioner received meet the definition of remedial care under federal law provided in 42 C.F.R. 440.60(a).

Accordingly, I **FIND** that the $4,000.00 expense which is still outstanding constitutes "amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party" under 42 U.S.C.A. § 1396a(r)(1)(A). Thus, I **CONCLUDE** that any remaining post-eligibility income of petitioner is to be applied to the $4,000.00 debt before applying it to a cost-share due the facility to offset Medicaid's payment and it is so **ORDERED.**

I hereby **FILE** my initial decision with the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES** for consideration.

This recommended decision may be adopted, modified or rejected by the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**, the designee of the Commissioner of the Department of Human Services, who by law is authorized to make a final decision in this matter. If the Director of the Division of Medical Assistance and Health Services does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within seven days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, Mail Code #3, P.O. Box 712, Trenton, New Jersey 08625-0712**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

Irene Jones

February 24, 2010
DATE

IRENE JONES, ALJ

Date Received at Agency: Feb. 24, 2010

Date Mailed to Parties:
sej

APPENDIX

WITNESSES

For Petitioner

Maria Johnson

For Respondent

Gregory Papazian

Alice Obelleiro

EXHIBITS

Joint Exhibits

P-J Joint Stipulation of Facts

For Petitioner

P-A Power of Attorney

P-B Clinical eligibility for Medicaid, dated January 15, 2008

P-C UCDA cost-share deduction denial letter, dated June 23, 2009, and Program Instruction No. GQ-PI-2008-03

P-D Petitioner's Cost-Share Worksheet

P-E Atria invoice concerning Petitioner's outstanding charges owed prior to receiving Medicaid

P-F Global Options waiver program approval letter, effective January 1, 2009.

P-G CMS State Medicaid Manual § 3703.8

P-H Appendix B-5 of New Jersey's waiver application

P-I Description of Supportive Living Plus services

P-K CMS opinion letter, dated September 13, 2004

For Respondent

R-1 N.J.A.C. 8:36 Standards for Licensure, definition of "Assisted Living Residence"