No. _____

IN THE

Supreme Court of the United States

GABRIELLE GOODWIN, BY DONNA ANSLEY,

Petitioner,

v.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES,

Respondent.

On Petition for a Writ of Certiorari to the District Court of Appeal of Florida, First District

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

A Medicaid beneficiary residing in a nursing home must pay a portion of the cost of her care to her nursing home in an amount that varies based on her income. Federal law requires that state Medicaid agencies calculate this cost-sharing obligation by deducting from the nursing-home resident's income, *inter alia*, any "incurred expenses" for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid. 42 U.S.C. § 1396a(r)(1)(A)(ii). Until the decision below, consistent with the clearly expressed intention of Congress and a longstanding interpretation by the Centers for Medicare & Medicaid Services ("CMS"), courts had uniformly concluded that under this provision states must deduct *pre-eligibility* medical expenses—i.e., medical debt that is not subject to payment by Medicaid because it was incurred prior to Medicaid eligibility—from a nursing-home resident's income when calculating her cost-sharing obligation. The decision below reached a contrary result by deferring to a state agency's interpretation of the federal statute.

The question presented is whether state Medicaid agencies may refuse to deduct medical debt incurred prior to Medicaid eligibility when calculating a nursing-home resident's cost-sharing obligation.

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PETITION FOR WRIT OF CERTIORARI

Gabrielle Goodwin respectfully petitions this Court to grant a writ of certiorari to review the judgment of the District Court of Appeal of Florida, First District.

OPINIONS BELOW

The final order of the Florida Department of Children and Families (Pet. App. 18a) is unreported. The opinion of the District Court of Appeal (Pet. App. 1a) is reported at 194 So. 3d 1042. The order of the District Court of Appeal denying rehearing or rehearing en banc (Pet. App. 14a) is unreported. The order of the Supreme Court of Florida denying the petition for review (Pet. App. 16a) is unreported.

JURISDICTION

The decision of the District Court of Appeal was entered on April 4, 2016. The District Court of Appeal denied rehearing or rehearing en banc on July 21, 2016. The Supreme Court of Florida denied the petition for review on December 8, 2016. This Court has jurisdiction under 28 U.S.C. § 1257(a).

STATUTORY PROVISION INVOLVED

42 U.S.C. § 1396a(r)(1)(A) provides:

> (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.

Regulatory provisions involved are included in the Appendix. *See* Pet. App. 28a, 35a.

STATEMENT

Petitioner incurred approximately $70,000 in unpaid medical debt from her nursing home prior to gaining Medicaid eligibility. Federal law requires that when a state Medicaid agency calculates a nursing-home resident's cost-sharing obligation, it deducts from her income any "incurred expenses for

medical or remedial care that are not subject to payment by a third party," including medical care "not covered" by Medicaid, subject to reasonable limits. 42 U.S.C. § 1396a(r)(1)(A)(ii). This deduction generally ensures that nursing-home residents can protect a portion of their income to pay medical bills for which they are personally responsible. Pursuant to this provision, Petitioner requested that Florida deduct from her income her pre-eligibility medical expenses, as they were not subject to payment by any third party, including Medicaid. Florida's Medicaid agency denied that federal law requires such a deduction, and the court below—deferring to the state agency's interpretation of federal law—agreed.

Congress enacted the provision at issue to overturn a CMS[1] rule that would have given states the discretion to do precisely what Florida did—choose not to deduct pre-eligibility medical expenses. Rather than permit states this discretion, Congress reinstated and codified a prior CMS rule, under which states were required to deduct pre-eligibility medical expenses. Consistent with Congress's instruction, CMS's current interpretation aligns with its prior rule—it requires states to deduct pre-eligibility medical expenses. Before the decision below, the courts that had reviewed this issue uniformly upheld this requirement.

[1] In this petition, we refer to both CMS and its predecessor agency, the Health Care Financing Administration, as "CMS."

I. Statutory and Regulatory Scheme

Medicaid is a federal-state partnership through which the federal government shares with participating states the cost of providing medical coverage to certain categories of low-income individuals. *See* 42 U.S.C. § 1396a (the "Medicaid Act"). In exchange for federal funding, states that elect to participate must comply with governing federal law. *See id.* § 1396a(a)(1). CMS, an agency within the U.S. Department of Health and Human Services ("HHS"), administers the Medicaid program for the federal government.

The Medicaid program allows participating states to cover both the "categorically needy"—i.e., "those individuals with incomes low enough to receive cash assistance"—and the "medically needy"—i.e., "persons who meet the non-financial eligibility requirements for cash assistance, but whose income or resources exceed the financial eligibility standards." Pet. App. 46a. Under the "spenddown" provision of the Medicaid Act, "the medically needy may qualify for Medicaid if they incur medical expenses in an amount that effectively reduces their income to the eligibility level." *Id.*; *see also* 42 U.S.C. § 1396a(a)(17). State Medicaid agencies determine if an individual is eligible under the spenddown provision by first subtracting "incurred medical expenses" from an individual's countable income, and then comparing the result to the income threshold for Medicaid eligibility. 42 C.F.R. § 435.831(d). Incurred medical expenses are defined as "medical expenses incurred . . . that are not subject to payment by a third party." *Id.* Such expenses include, *inter alia*, certain

expenses for medical services that are "included in the [State Medicaid] plan," *id.* § 435.831(e)(3), but were incurred prior to the individual's filing of her Medicaid application, *id.* § 435.831(f).

Once an individual satisfies Medicaid eligibility requirements, the medical expenses she incurred may be relevant to a separate calculation—the amount she must contribute to the cost of her care if she resides in a nursing home. *See id.* § 435.725(a).[2] Federal law specifies the manner in which states must calculate a nursing-home resident's Medicaid cost-sharing obligation. The payment equals the beneficiary's total income, reduced by federally defined deductions. *See id.* Similar to the spenddown calculation, states are required to deduct "amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party." 42 U.S.C. § 1396a(r)(1)(A); 42 C.F.R. § 435.725(c)(4). Such expenses include those incurred for "necessary medical or remedial care recognized under State law but not covered under the State [Medicaid] plan . . . , subject to reasonable limits the State may establish on the amount of these expenses." 42 U.S.C. § 1396a(r)(1)(A)(ii); *see* 42 C.F.R. § 435.725(c)(4)(ii).[3] "Reasonable limits (if any) must

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[2] This calculation applies not only to Medicaid beneficiaries in nursing homes, but also to Medicaid beneficiaries receiving home and community-based services under certain state Medicaid programs that fund such services as an alternative to institutional care. *See* 42 C.F.R. § 435.726; *id.* § 435.735.

[3] The language at issue in this case also appears in the regulations governing Medicaid beneficiaries receiving home and community-based services, *see* 42 C.F.R. § 435.726(c)(4)(ii); *id.* § 435.735(c)(4)(ii), as well as other regulations governing Medicaid beneficiaries receiving care in nursing homes under various

be submitted by [a state Medicaid agency] for approval by [CMS] in the Medicaid State plan." State Medicaid Manual § 3703.8 (1989). CMS explained that the purpose of this deduction is to protect a portion of a nursing-home resident's income to ensure that she has "the ability to pay non-covered medical expenses for medical or remedial care." Pet. App. 56a.

The medical-expense deduction was, before 1988, not part of the Medicaid Act, but was solely part of the governing regulation. That regulation, like the current statute, required states to deduct "incurred expenses" for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid. 43 Fed. Reg. 45,176, 45,213 (Sept. 29, 1978). In 1988, CMS finalized a rule giving states the option to refuse this deduction—a marked change from CMS's prior policy. 53 Fed. Reg. 3586, 3588 (Feb. 8, 1988). CMS stated that this change would affect the treatment of *pre-eligibility* medical expenses—i.e., medical expenses incurred prior to Medicaid eligibility. The agency explained that pre-eligibility expenses were a required deduction under its pre-1988 regulation because that regulation required states to deduct medical expenses "not covered" by Medicaid, and pre-eligibility medical expenses are "not covered" by Medicaid. *See id.* at 3589 ("Services furnished to an individual during a period of ineligibility are services not covered under the State plan."). But because the new CMS rule made medical expenses "not covered" by Medicaid an optional deduction, states would no longer be required

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types of state Medicaid programs, *see id.* § 435.733(c)(4)(ii); *id.* § 435.832(c)(4)(ii).

to deduct pre-eligibility medical expenses. *See id.* (explaining that under the new rule states are not "required to deduct medical expenses for services furnished during a period of ineligibility, and may limit deductions to services within the budget period").

Congress promptly reversed the CMS rule. As part of the Medicare Catastrophic Coverage Act of 1988, Congress enacted 42 U.S.C. § 1396a(r)—the statute at issue in this case, the relevant portion of which has not changed.[4] *See* Pub. L. No. 100-360, § 303(d), 102 Stat. 683, 762. This statute adopted precisely the same relevant language from CMS's pre-1988 regulation relating to medical-expense deductions; it too required states to deduct "incurred expenses" for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid.[5] *Id.* Congress made the new statutory

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[4] Congress has amended this statute twice, but has never changed the portion that requires states to deduct "incurred expenses" for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4715, 111 Stat. 251, 510–11 (adding subparagraph (B) relating to the treatment of veterans' pensions); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4715, 104 Stat. 1388, 1388-192 (requiring the deduction of German repatriation payments).

[5] The pre-1988 regulation and the statute enacted in 1988 contained only trivial differences. *Compare* 43 Fed. Reg. at 45,213 (requiring states to deduct "[a]mounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including . . . [n]ecessary 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"), *with* Pub. L. No.

provision retroactive to the effective date of the CMS rule and confirmed that it would supersede the CMS rule. *See id.* § 303(g)(4), 102 Stat. at 764. A House Conference Report explained that, by enacting 42 U.S.C. § 1396a(r), Congress "intended to reinstate the previous [CMS] rule." H.R. Rep. 100-661, at 266 (1988) (Conf. Rep.).

Consistent with its pre-1988 rule that Congress adopted, CMS's current regulations require states to deduct pre-eligibility medical expenses. CMS confirmed this requirement in *The Disapproval of the Maryland State Plan Amendment* 05-06, a final administrative action disapproving a State Plan Amendment submitted by the Maryland Department of Health and Mental Hygiene ("Maryland"). Pet. App. 57a. The Maryland State Plan Amendment would have permitted nursing-home residents to deduct only medical expenses "incurred during a period of eligibility for Medicaid." Pet. App. 42a. CMS disapproved the State Plan Amendment as contrary to 42 U.S.C. § 1396a(r)(1)(A), which CMS interpreted as requiring states to deduct pre-eligibility medical expenses. *See* Pet. App. 56a. The U.S. Court of Appeals for the Fourth Circuit upheld CMS's disapproval of the Maryland State Plan Amendment. *Md. Dep't of Health & Mental Hygiene*

100-360, § 303(d), 102 Stat. at 762 (requiring states to deduct "amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including . . . necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses").

v. Ctrs. for Medicare & Medicaid Servs., 542 F.3d 424 (4th Cir. 2008).

II. Factual and Procedural Background

Petitioner Gabrielle Goodwin is severely disabled as a result of a spinal cord injury and subsequent surgical complications. In November 2010, she entered Heritage Healthcare Center ("Heritage"), a nursing home in Tallahassee, Florida. Pet. App. 20a. She applied for Medicaid coverage in January 2012, and she was approved retroactive to December 1, 2011. *Id.* Prior to December 1, 2011—her date of Medicaid eligibility—she had incurred approximately $70,000 in unpaid nursing home charges at Heritage. Pet. App. 4a.[6]

In Florida, the cost-sharing obligation imposed on Medicaid beneficiaries in nursing homes is called the "patient responsibility amount," or "PRA." Pet. App. 3a. The Florida Department of Children and Families ("DCF") initially calculated Petitioner's PRA as approximately $1,000 per month, an amount that disregarded her $70,000 debt to Heritage from pre-eligibility medical expenses. *Id.* Had DCF deducted her unpaid pre-eligibility nursing-home expenses, Petitioner's monthly PRA would have been $0, rather than approximately $1,000, for the roughly 70 months it would have taken her to use that protected $1,000 per month to extinguish her pre-eligibility medical debt. Petitioner requested that DCF deduct her pre-

[6] Petitioner now receives Medicaid assistance in a community-based care setting.

eligibility medical expenses when calculating her PRA, but DCF denied the deduction. Pet. App. 4a.

Petitioner appealed the denial to DCF's Office of Appeal Hearings, arguing that DCF's refusal to deduct her pre-eligibility medical expenses violated federal law—specifically, 42 U.S.C. § 1396a(r)(1)(A). Pet. App. 4a, 24a. DCF denied her appeal. Pet. App. 26a. The then-governing Florida regulation concerning medical-expense deductions, Fla. Admin. Code Ann. r. 65A-1.7141(g) (2005), stated that a deduction would be permitted only for medical care that, *inter alia*, is not a "Medicaid compensable expense," and that projections of anticipated expenses based on past expenses would be permitted only for "recurring" expenses. Pet. App. 37a. DCF held that Petitioner's pre-eligibility expenses for nursing home care are not required deductions because nursing home care is "compensable" under Florida's Medicaid program and Petitioner's pre-eligibility medical expenses are not "recurring." Pet. App. 25a–26a.

Petitioner appealed DCF's final order to the District Court of Appeal, again arguing that DCF had calculated her PRA in violation of federal Medicaid law.[7] Pet. App. 5a. DCF initially moved to dismiss

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[7] She also filed a class action in Florida state court raising the same issue. *See Goodwin v. Fla. Agency for Health Care Admin.*, 194 So. 3d 1041 (Fla. Dist. Ct. App. 2016). The District Court of Appeal stayed the present case pending a ruling in trial court on the class action. *See* Pet. App. 4a–5a. The trial court denied class certification, and the District Court of Appeal ultimately affirmed because, having lost her challenge on the merits (i.e., the present case), Petitioner did not "possess standing to represent the class." *Id.* at 1042.

the appeal as moot because CMS had approved an intervening Florida State Plan Amendment that permitted nursing-home residents to deduct medical expenses incurred in the three months prior to eligibility.[8] *Id.* But DCF continued to maintain that federal law had imposed no obligation to deduct Petitioner's pre-eligibility medical expenses when DCF initially calculated her PRA. *See* Pet. App. 9a. DCF's posture had significant financial consequences for Petitioner. The three-month limit was not effective when Petitioner became eligible for Medicaid coverage and began incurring PRA charges.[9] However, on the basis of its view that federal law did not require *any* deduction of pre-eligibility medical expenses, DCF denied Petitioner the full deduction she had initially claimed and instead deducted only three months of her pre-eligibility medical expenses.[10]

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[8] The statute at issue permits states to establish "reasonable limits" on the amount of medical expenses a beneficiary may deduct, 42 U.S.C. § 1396a(r)(1)(A)(ii), subject to approval by CMS, State Medicaid Manual § 3703.8. The three-month period for pre-eligibility medical expenses proposed by Florida and approved by CMS was such a reasonable limit.

[9] Petitioner gained Medicaid eligibility on December 1, 2011. The Florida State Plan Amendment was submitted on December 21, 2012, and consistent with federal regulations approved by CMS effective December 13, 2012. *See* 42 C.F.R. § 447.256(c). The three-month limit authorized by the State Plan Amendment was not made legally effective under Florida law until August 12, 2015. *See* Fla. Admin. Code Ann. r. 65A-1.7141 (2015).

[10] If DCF did not take this position, Florida law would preclude retroactive application of the new three-month limit to Petitioner. Indeed, if DCF acknowledged that Petitioner was correct about the meaning of federal law, retroactive application of the new three-month limit would "impair or destroy [her]

See Pet. App. 5a. Petitioner explained to the District Court of Appeal that the appeal was not moot because, if she prevailed on her federal statutory interpretation argument, she (like the many other Florida nursing-home residents who had claims pre-dating the effective date of the new three-month limit) was entitled to a deduction of *all* of her pre-eligibility medical expenses. The District Court of Appeal denied DCF's motion to dismiss. *Id.*

On the merits, the District Court of Appeal affirmed DCF's denial of Petitioner's claim for a full deduction. The court viewed the dispute as between two competing interpretations of the word "covered" in 42 U.S.C. § 1396a(r)(1)(A). Pet. App. 8a. In Petitioner's view, consistent with CMS's longstanding position, pre-eligibility expenses for nursing-home care are *not* "covered" by Medicaid because Medicaid does not pay for them. *Id.* In DCF's view, pre-eligibility expenses for nursing-home care *are* "covered" by Medicaid because nursing home care is a covered service in Florida's Medicaid program. Pet. App. 9a. The court believed that both DCF and Petitioner had offered a "reasonabl[e]" construction of the federal statute, but it ruled against Petitioner because it held that, in interpreting this provision of *federal* law, it owed deference to DCF, the *state* agency, rather than CMS, the *federal* agency. Pet. App. 10a. The court dismissed CMS's interpretation of the federal statute, as explained in its disapproval

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existing rights" to a full deduction, *State v. Lavazzoli*, 434 So. 2d 321, 323 (Fla. 1983) (citation omitted), and would improperly subject her to a regulation that does not "merely clarif[y] another existing rule," *Envtl. Tr. v. Dep't of Envtl. Prot.*, 714 So. 2d 493, 499–500 (Fla. Dist. Ct. App. 1998).

of the Maryland State Plan Amendment, as a "litigation position" that is not "binding" in Florida. Pet. App. 11a.[11] It concluded by rejecting Petitioner's alternative arguments concerning the applicability of the state rule that DCF initially invoked to justify its refusal to deduct any pre-eligibility expenses. Pet. App. 11a–12a.

The District Court of Appeal denied rehearing, Pet. App. 14a, and the Supreme Court of Florida declined to accept jurisdiction, Pet. App. 16a.

REASONS FOR GRANTING THE PETITION

I. The Decision of the District Court of Appeal Has Created a Clear and Irreconcilable Split Over the Requirements Imposed by Federal Medicaid Law

The Fourth Circuit and the Supreme Court of Montana held that federal law requires Maryland and Montana respectively to afford nursing-home residents a deduction for pre-eligibility medical

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[11] The court also faulted Petitioner for not citing in her administrative appeal the Fourth Circuit's decision upholding CMS's disapproval of Maryland's State Plan Amendment. Pet. App. 10a. In the court's view, Petitioner "needed to argue below that *Maryland* controls DCF's interpretation before raising it" with the District Court of Appeal. *Id.* The court acknowledged, however, that Petitioner had preserved the central issue of whether "the federal statute's bare language required DCF to recalculate her PRA." *Id.* The meaning of that federal statute is the question before this Court. *See Yee v. City of Escondido*, 503 U.S. 519, 534 (1992) ("Once a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below.").

expenses. In holding that federal law imposes no such requirement in Florida, the decision below diverged from a consistent and longstanding interpretation of federal Medicaid law by CMS, the agency charged with administering the Medicaid program, and the courts that had previously considered precisely the same question. This decision has produced uncertainty and dissonance in the enforcement of federal law governing Medicaid—a federally funded program with significant economic implications for states and some of their most vulnerable residents. Perhaps due to that important consideration, this Court has previously granted certiorari when a state court similarly diverged from the interpretation of the Medicaid Act adopted by CMS and most other courts. *See Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 489 (2002) (reversing a state intermediate appellate court's interpretation of the Medicaid Act relating to income protections for nursing-home residents and their families). We urge this Court here as well to reestablish clarity in federal Medicaid law.

In *Maryland Department of Health & Mental Hygiene v. Centers for Medicare & Medicaid Services*, 542 F.3d 424 (4th Cir. 2008), Maryland petitioned the Fourth Circuit to review CMS's disapproval of Maryland's proposed State Plan Amendment that would have prohibited nursing-home residents from deducting pre-eligibility medical expenses. CMS had disapproved the Maryland State Plan Amendment as contrary to federal law because, under CMS's interpretation of the Medicaid Act, Congress had reinstated CMS's policy requiring states to deduct pre-eligibility medical expenses. *See* Pet. App. 56a.

The Fourth Circuit upheld CMS's decision. The court began by finding that Congress had "explicitly delegated the authority to prescribe the standards for determining . . . deductions for medical expenses" to CMS—"not the states." *Maryland*, 542 F.3d at 433. Because the court viewed the statutory phrase at issue—"not covered under the State plan"—as ambiguous, it considered next whether CMS's interpretation of the phrase was reasonable. *See id.* at 433–34. The court explained that, by "overturn[ing]" the 1988 CMS rule that had permitted states to refuse deductions for pre-eligibility medical expenses, Congress had "foreclosed any possibility that states could limit or eliminate post-eligibility deductions for incurred medical expenses without CMS's prior approval." *Id.* at 435. Relying in large part on this statutory context, the court upheld CMS's requirement that states deduct pre-eligibility medical expenses. *See id.* at 435–37.

The Supreme Court of Montana reached the same conclusion in *Timm v. Montana Department of Public Health & Human Services*, 184 P.3d 994 (Mont. 2008). Appellant Linda Timm, who was in an advanced stage of multiple sclerosis, entered a nursing home approximately twenty months before she and her husband became eligible for Medicaid. *See id.* at 997, 999. From Ms. Timm's pre-eligibility nursing home care, "the Timms were left with an outstanding medical debt of over $35,000.00 for which they were personally responsible." *Id.* at 999. When the Montana Department of Public Health and Human Services ("Montana") calculated Ms. Timm's cost-sharing obligation to her nursing home, it refused to deduct her $35,000 debt, and consequently assessed

her cost-sharing obligation at $1,123.40 per month. *Id.* Although federal and state law required Montana to deduct expenses for medical care not "covered" by Medicaid, Ms. Timm's un-covered nursing-home bills were, in Montana's view, "covered" nonetheless "because Medicaid would have paid for [them] had she been eligible" when she incurred them. *Id.* at 1000. On this basis, Montana denied the Timms' plea for a deduction. *Id.*

The Supreme Court of Montana held that this denial violated federal law. Like the Fourth Circuit, the court in *Timm* began by acknowledging CMS's "broad authority" to interpret the Medicaid Act. *Id.* at 1006 (quoting *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)). In the court's view, Montana was "bound to follow" CMS's interpretation of 42 U.S.C. § 1396a(r)(1)(A). *Id.* The court explained that CMS had decided that "costs incurred for services prior to Medicaid eligibility must be considered 'not a Medicaid covered service' so long as they were not actually covered by Medicaid." *Id.* The court accordingly held that Montana must permit Ms. Timm to deduct her pre-eligibility nursing home expenses from her cost-sharing obligation. *Id.*

The decision below is in square conflict with the decisions of the Fourth Circuit and the Supreme Court of Montana, as to both their reasoning and their results. With respect to the former, the Florida District Court of Appeal wholly ignored the context in which Congress added the provision at issue to the Medicaid Act. In contrast, both the Fourth Circuit and the Supreme Court of Montana explained that Congress enacted 42 U.S.C. § 1396a(r) with the

explicit intention of reinstating a CMS rule under which pre-eligibility medical expenses were a required deduction. *See Maryland*, 542 F.3d at 435; *Timm*, 184 P.3d at 1006. And while the Florida District Court of Appeal deferred to a state agency on the interpretation of federal law, Pet. App. 10a, both the Fourth Circuit and the Supreme Court of Montana deferred to CMS, the federal agency that Congress charged with interpreting the Medicaid Act, *see Maryland*, 542 F.3d at 433; *Timm*, 184 P.3d at 1006. As to the result, the Fourth Circuit and the Supreme Court of Montana held that federal law requires states to deduct pre-eligibility medical expenses. *See Maryland*, 542 F.3d at 437; *Timm*, 184 P.3d at 1006. The Florida District Court of Appeal held that the opposite rule applies in Florida. *See* Pet. App. 10a. These decisions are irreconcilable.

II. The Decision of the District Court of Appeal Is Contrary to Federal Law

Florida's interpretation of federal law is in clear conflict with the text of 42 U.S.C. § 1396a(r)(1)(A), Congress's clearly expressed intent in enacting it, and CMS's binding interpretation of it. Rather than properly interpret the statute or defer to the concededly reasonable interpretation by the federal agency to which Congress granted regulatory authority over the Medicaid Act, the decision below erroneously deferred to the state's interpretation of federal law. This decision is wrong and should be reversed.

Resort to principles of agency deference is not necessary to resolve this case. The text of the statute

is definitive. It requires the deduction of "incurred" expenses for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid. 42 U.S.C. § 1396a(r)(1)(A). This language plainly covers pre-eligibility medical expenses, for at least two reasons.

First, the text is concerned with whether a third party, including Medicaid, would actually pay an expense—not, as Florida claims, whether the type of service received is generally compensable under the Medicaid program. The statute references medical care "not covered" by Medicaid as a subset of medical care "not subject to payment by a third party." Put another way, medical care "not covered" by Medicaid is among the medical care not subject to third-party payment. By placing medical care "not covered" by Medicaid within the category of medical care "not subject to payment by a third party," the statute tells its reader that Medicaid *coverage* is synonymous with Medicaid *payment*. Because Medicaid does not pay for pre-eligibility medical expenses, such expenses are "not covered" within the meaning of the statute.

Second, the statute refers to "incurred" expenses. This is the same language that Congress used in the spenddown statute, which requires participating states to take into account costs "incurred for medical care" by medically needy individuals whose incomes would otherwise be above the Medicaid threshold. 42 U.S.C. § 1396a(a)(17). The spenddown statute and its implementing regulations unquestionably apply to certain pre-eligibility medical expenses, including medical expenses for services that would be compensable by Medicaid. *See* 42 C.F.R. §

435.831(e)(3), (f). "The substantial relation between the two programs presents a classic case for application of the 'normal rule of statutory construction that 'identical words used in different parts of the same act are intended to have the same meaning.'" *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990) (citations omitted). Here, that canon counsels in favor of reading "incurred" expenses in the statute at issue to also apply to pre-eligibility medical expenses.[12]

Even if the text alone were not clear enough, the context in which Congress enacted it resolves any ambiguities. As explained above, before 1988 CMS required states to deduct "incurred expenses" for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid. 43 Fed. Reg. at 45,213. In 1988, when CMS finalized a rule making this deduction optional, the agency made clear that this change would affect the treatment of pre-eligibility medical expenses. CMS explained, specifically, that "[s]ervices furnished to an individual during a period of ineligibility are

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[12] The relationship between the spenddown process and the nursing-home cost-sharing calculation was important to CMS's reasoning in disapproving the Maryland State Plan Amendment. CMS explained that its interpretation of the nursing-home cost-sharing statute—requiring states to deduct pre-eligibility medical expenses—would "treat incurred medical expenses consistently in both the spenddown and post-eligibility processes." Pet. App. 56a. In CMS's view, "[f]ailure to protect income to pay for non-covered expenses which were used to establish eligibility under the medical needy spend down . . . would undercut the purpose of requiring States to deduct incurred expenses under the spend down provisions." Pet. App. 56–57a.

services not covered under the State plan." 53 Fed. Reg. at 3589. Pre-eligibility medical expenses were, therefore, a required deduction under the pre-1988 CMS rule, but an optional deduction under the new one.

Congress promptly reversed the new CMS rule by enacting 42 U.S.C. § 1396a(r)—the statute at issue, which has not changed in any relevant respect.[13] Congress made clear in at least three ways that its intention was to reinstate the pre-1988 CMS rule. First, the statute adopted the same relevant language as the pre-1988 CMS rule; it required states to deduct "incurred expenses" for medical care "not subject to payment by a third party," including medical care "not covered" by Medicaid. Pub. L. No. 100-360, § 303(d), 102 Stat. at 762. Second, Congress itself said so; a House Conference Report stated that Congress "intended to reinstate the previous [CMS] rule." H.R. Rep. 100-661, at 266. Third, Congress made the new statutory provision retroactive to the effective date of the new CMS rule, and stated that the new CMS rule was "superseded" by the statute. Pub. L. No. 100-360, § 303(g)(4), 102 Stat. at 764. This context demonstrates beyond peradventure that Congress intended to, and did, reinstate and codify the pre-1988 CMS rule.

There is, therefore, only one permissible construction of the statute: like the pre-1988 CMS rule it codified, the statute requires states to deduct pre-eligibility medical expenses. A contrary interpretation would ignore clear congressional

[13] *See* note 4, *supra*.

intent, as expressed not only through a House Conference Report, but also through Congress's choice to adopt the relevant language of CMS's pre-1988 rule. This case is far stronger than one of mere congressional acquiescence, such as when congressional inaction supports an inference that Congress agrees with an administrative interpretation, *see N. Haven Bd. of Ed. v. Bell*, 456 U.S. 512, 534–35 (1982), or when congressional re-enactment of a statute without change provides evidence that Congress approves of an administrative interpretation, *see Fed. Deposit Ins. Corp. v. Philadelphia Gear Corp.*, 476 U.S. 426, 437 (1986). Here, Congress explicitly reinstated a CMS rule that had interpreted medical expenses "not covered" by Medicaid to include pre-eligibility medical expenses and had required states to deduct such expenses. By doing so, Congress unequivocally ratified CMS's required deduction of pre-eligibility medical expenses. *See Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986) ("Where, as here, 'Congress has not just kept its silence by refusing to overturn the administrative construction, but has ratified it with positive legislation,' we cannot but deem that construction virtually conclusive." (citations omitted)).

If there were any question as to what Congress meant by "not covered" in the Medicaid Act, CMS has acted well within the bounds of reasonable interpretation in construing that phrase to include pre-eligibility medical expenses. This Court "long ha[s] recognized that, perhaps due to the intricacy of the [Medicaid] Act, 'Congress conferred on the Secretary [of HHS] exceptionally broad authority to prescribe standards for applying certain sections of

the Act.'" *Atkins v. Rivera*, 477 U.S. 154, 162 (1986) (quoting *Gray Panthers*, 453 U.S. at 43). This broad authority is reflected in 42 U.S.C. § 1302(a), which grants HHS the authority to "make and publish such rules and regulations . . . as may be necessary to the efficient administration of the functions with which [it] is charged under [the Social Security] Act." It is also reflected in 42 U.S.C. § 1396a(a)(17), which grants HHS administrative authority related to the calculation of the "income and resources" of Medicaid beneficiaries, as well as costs "incurred for medical care." This Court has stated that this provision is an "explicit grant of rulemaking authority" to HHS. *Atkins*, 477 U.S. at 162. "It is the Secretary [of HHS], therefore, not the states, to whom Congress has explicitly delegated the authority to prescribe the standards for determining eligibility, available income, and deductions for medical expenses." *Maryland*, 542 F.3d at 433. HHS has delegated its authority in this area to CMS, *see Blumer*, 534 U.S. at 479 n.1, and CMS acted pursuant to this vast regulatory authority when it interpreted 42 U.S.C. § 1396a(r)(1)(A) to require states to deduct pre-eligibility medical expenses.

The court below held that it need not defer to CMS because the agency's interpretation of the Medicaid Act, as reflected in its disapproval of Maryland's State Plan Amendment, was a mere "litigation position." Pet. App. 11a. Not so. CMS's disapproval of Maryland's State Plan Amendment, by its own terms, "constitutes the final administrative decision of the Secretary of Health and Human Services." Pet. App. 57a. Pursuant to CMS regulations, such a decision "constitutes 'final agency action' within the meaning

of 5 U.S.C. § 704 and a 'final determination' within the meaning of section 1116(a)(3) of the [Social Security] Act and [42 C.F.R.] § 430.38." 42 C.F.R. § 430.102(c); *see also Timm*, 184 P.3d at 1005 n.4. CMS's decision is, therefore, agency action "carrying the force of law" that qualifies for deference. *United States v. Mead Corp.*, 533 U.S. 218, 227 (2001).

The court below compounded its erroneous refusal to defer to CMS with its unwarranted decision to defer to a *state* agency's interpretation of *federal* law. Such deference is clearly inappropriate, at least where the state agency's interpretation has not been approved by the federal agency to which Congress has granted interpretive authority (and, indeed, is contrary to the federal agency's interpretation). *See Perry v. Dowling*, 95 F.3d 231, 236 (2d Cir. 1996).[14] Deferring in that circumstance is inconsistent with some of the fundamental principles underlying this Court's *Chevron* doctrine. While the legitimacy of

[14] The question of whether deference is ever due to state agencies interpreting federal law is the subject of recent judicial and academic discussion. *See Exelon Wind 1, L.L.C. v. Nelson*, 766 F.3d 380, 400 (5th Cir. 2014) (Prado, J., concurring in part and dissenting in part); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 Yale L.J. 534 (2011). Courts have seemingly taken different views on this question. *Compare Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1495–96 (9th Cir. 1997) ("A state agency's interpretation of federal statutes is not entitled to the deference afforded a federal agency's interpretation of its own statutes under *Chevron* . . . ."), *with Clark v. Alexander*, 85 F.3d 146, 152 (4th Cir. 1996) ("If there is no inconsistency [with federal law], the court should afford the state agency's action reasonable deference, meaning that the action should be upheld unless it is found to be arbitrary or capricious.").

deference depends in large part on the "background presumption" that Congress intends to delegate interpretive authority to a federal agency charged with implementing a federal statute, *City of Arlington, Tex. v. FCC*, 133 S. Ct. 1863, 1868 (2013), no similar presumption exists that Congress intends to delegate interpretive authority over the meaning of federal law to state agencies. Deferring to federal agencies, moreover, promotes the "value of uniformity" in the "understandings of what a national law requires," *Mead*, 533 U.S. at 234, while deferring to state agencies would produce the opposite effect.

Deference to CMS is warranted in this case because CMS is the agency that Congress explicitly charged with implementing the Medicaid Act, and its interpretation is consistent with the statute and is reasonable. The best interpretation of the statutory text is, as explained above, the one CMS adopted. And even if it were not, Florida's interpretation—that the statute requires medical expense deductions only for medical care that is not Medicaid *compensable*—is clearly not required by the statutory text. The statute itself refers to medical care "not covered" by Medicaid—not medical care "not compensable" by Medicaid. CMS's interpretation is also reasonable. As CMS explained, its interpretation ensures consistency in the "spenddown and post-eligibility processes," Pet. App. 56a, and aligns with Congress's decision in 1988 to "reinstate [CMS's] policy" that had required states to deduct medical expenses for "services incurred during a period of ineligibility," *id.*

III. The Court's Prompt Review Is Warranted

A. This Case is of Great Importance to Nursing-Home Residents Across the Nation

"At issue" in this case is the "financial well-being of nursing home residents." *Maryland*, 542 F.3d at 427. The rule announced by the decision below would permit states to subject nursing-home residents on Medicaid to excessive cost-sharing charges for their nursing home care, despite the fact that these nursing-home residents owe often-large sums of medical debt.[15] States that refuse to deduct pre-eligibility medical expenses are effectively preventing nursing-home residents from using their income to pay down their medical bills, thereby impeding the ability of nursing-home residents to gain the financial freedom to transition from nursing-home care to home and community-based care, and ensuring that if they are able to exit nursing-home care they will return home saddled by the burden of medical debt. These

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[15] In *Maryland*, the state estimated that the amount at stake in Maryland was $93 million annually. *See* 542 F.3d at 427 n.4. Policies relating to Medicaid payment for nursing-home care are, indeed, of substantial economic importance. "In 2013, Medicaid outlays for institutional and community-based [long-term services and supports] totaled just over $123 billion . . . ." Erica L. Reaves & MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer*, Kaiser Family Found. 3 (2015), *available at* http://kff.org/report-section/medicaid-and-long-term-services-and-supports-a-primer-report-dec-2015. The importance of such policies is likely to increase, as the "number of elderly Americans is expected to more than double in the next 40 years," with "an estimated 70 percent" of people age 65 and over projected to use long-term services and supports. *Id.* at 2.

policies, moreover, put nursing-home residents at a greater risk of being discharged from the care they need, as a patient's non-payment of medical debt can allow a nursing home to discharge her, *see* 42 C.F.R. § 483.15(c)(1)—a potentially appealing option to nursing homes that, for example, wish to replace a Medicaid beneficiary with a patient who has higher-paying private insurance. In short, honoring the federal requirement that nursing-home residents receiving Medicaid be permitted to deduct pre-eligibility medical expenses is vitally important to maintaining the financial solvency and well-being of an especially vulnerable population.

This case has significant implications for nursing-home residents not only in Florida,[16] but across the nation. Despite CMS's express policy of requiring states to deduct pre-eligibility medical expenses, several states refuse to do so. Unlike Maryland, however, the non-compliant states have not asserted their interpretations of the statute in a State Plan Amendment requiring CMS approval. These states, instead, set out their non-compliant policies in regulations or guidance, or through an administrative practice, all of which are not subject to CMS approval.

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[16] Although Florida has amended its State Plan to provide a deduction for three months of pre-eligibility medical expenses, the decision below permits Florida to deny a full deduction to Petitioner and all other Florida nursing-home residents with claims pre-dating the effective date of the new limit. For Petitioner and others similarly situated, the financial stakes remain high. Petitioner, for example, would be entitled to deduct all $70,000 of her pre-eligibility medical expenses if she prevails. If Florida prevails, Petitioner's deduction will be limited to less than one quarter of her medical debt.

Many states, moreover, have no clear policies relating to pre-eligibility medical expenses, leaving beneficiaries and their advocates without any guidance as to the deductions that they can claim.

Reversing the decision below is, therefore, critical to ensuring prompt, nationwide compliance with federal Medicaid law. Doing so would reverse explicitly non-compliant policies in several states and put every state on notice of its obligations to nursing-home residents under the Medicaid Act. Because many states are adopting non-compliant policies outside of CMS's direct purview (or adopting no policies at all), review by this Court is likely the only route to uniform compliance with the Medicaid Act. Leaving in place the decision below would not only delay the efforts toward nationwide compliance, but it would undermine them by emboldening states that would prefer to pay a lesser share of the cost of nursing-home care for Medicaid beneficiaries. Indeed, at least one state has already relied on the decision below as a justification for this practice, and other states may be similarly emboldened if the decision below is not reversed.

The following four states have either explicitly refused to deduct pre-eligibility medical expenses, or adopted regulations or guidance that strongly suggest non-compliance. The second-largest state by population—Texas—is among them. Although many additional states may lack clear policies relating to pre-eligibility medical expenses, reversing the decision below would affect at least the following states.

Arkansas. Although the Arkansas State Plan does not address pre-eligibility medical expenses, the Office of Chief Counsel ("OCC") of the Arkansas Department of Human Services ("Arkansas" or "DHS") stated in an April 19, 2016, memorandum that pre-eligibility nursing-home expenses are not eligible for a deduction in Arkansas. *See* Pet. App. 59a. Arkansas has defended this position by relying principally on the decision below. In a brief before its Office of Appeals and Hearings, Arkansas argued that, just as the Florida Medicaid agency received deference from the court below, deference in Arkansas was due to the Arkansas Medicaid agency. *See* Pet. App. 63a–66a. In Arkansas's words: "[A]s the court in *Goodwin* acknowledged, in situations such as the one at hand, it is DHS's interpretation which must be given deference since DHS is the enforcing agency." Pet. App. 65a. Arkansas also repeated the Florida District Court of Appeal's erroneous conclusion that CMS's interpretation was a "mere litigation position," Pet. App. 63a, and argued on this basis that it was not worthy of deference, Pet. App. 64a–65a. The Office of Appeals and Hearings concurred with DHS's position and held that a beneficiary could not deduct pre-eligibility medical expenses. *See* Pet. App. 69a–70a.

Mississippi. The Mississippi State Plan does not address pre-eligibility medical expenses, but sub-regulatory guidance (i.e., the Mississippi Medicaid website[17]) appears to exclude such expenses as an

[17] *Aged, Blind or Disabled Residing in Nursing Homes or Participating in Home and Community Based Waiver Programs*, Miss. Div. of Medicaid, https://medicaid.ms.gov/medicaid-coverage/who-qualifies-for-coverage/aged-blind-or-disabled-living-in-nursing-homes/ (last visited Mar. 1, 2017).

allowable deduction. Mississippi refers to a nursing-home resident's cost-sharing obligation as "Medicaid income." On the list of deductions Mississippi allows in the calculation of Medicaid income, only one line relates to medical expenses. It allows a deduction for "[c]ertain medical expenses that would ordinarily be paid for by Medicaid but, due to service limits placed on these services, the recipient is charged for the expense." This language does not encompass pre-eligibility medical expenses, which are not paid in part by Medicaid and are not subject to Medicaid service limits.[18]

Oklahoma. In Oklahoma, a nursing-home resident's cost-sharing obligation is called a "vendor payment." State regulations provide the manner in which the vendor payment is calculated, including the deduction for certain medical expenses. Like Arkansas, Oklahoma's State Plan does not address pre-eligibility medical expenses. Oklahoma's regulations, however, do not permit any deductions for pre-eligibility medical expenses. They instead limit the medical-expense deduction to "the actual monthly payments being made for medical insurance premiums including Medicare premiums." Okla. Admin. Code § 317:35-19-21(b)(1)(C); *see also id.* § 317:35-9-68(b)(1)(C) (limiting the medical-expense deduction in the same manner for beneficiaries in an intermediate care facility for individuals with intellectual disabilities). Because this policy is set out

[18] An Eligibility and Special Projects Analyst in the Mississippi Division of Medicaid confirmed in an email on March 1, 2017, that the state does not deduct pre-eligibility medical expenses.

in a state regulation, but not in Oklahoma's State Plan, it has not come before CMS for review.

Texas. The Texas State Plan allows deductions for "non-covered" medical expenses incurred within three months prior to Medicaid eligibility. Although the State Plan does not define "non-covered," state guidance instructs that Texas does not permit *any* deductions for pre-eligibility medical expenses. Rules relating to Texas's calculation of a nursing-home resident's cost-sharing obligation (in Texas, a "co-payment") appear in the Texas Health and Human Services *Medicaid for the Elderly and People with Disabilities Handbook*. Section H-2150 of that handbook provides a list of incurred medical expenses for which the Texas Health and Human Services Commission will not allow a deduction. That list includes "expenses for medical services received before the applicant's medical effective date." Pet. App. 71a.[19] Unlike its State Plan, Texas's non-compliant handbook does not require CMS approval.

B. This Petition Presents a Rare Vehicle to Resolve the Question Presented

We respectfully urge the Court to grant this petition because it is a proper vehicle to decide the important question presented, and the Court is unlikely to see a better one.

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[19] The Texas handbook is also available online. *See Medicaid for the Elderly and People with Disabilities Handbook*, Tex. Health & Human Servs., https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook/chapter-h-co-payment/mepd-h-2000-incurred-medical-expenses-0 (last visited Mar. 1, 2017).

This petition is an appropriate vehicle to decide the question presented. The issue of federal statutory interpretation is squarely presented, the parties "vigorously disagree" on the answer, Pet. App. 8a, and the issue was addressed and decided by the court below. There is, moreover, no antecedent issue in this case that the Court would need to address. The only question remaining in this case is the federal question, and it is dispositive. That Florida has adopted a State Plan Amendment permitting some pre-eligibility deductions is immaterial. Florida continues to dispute that federal law requires the deduction of pre-eligibility medical expenses, ensuring that the parties remain adverse. And the parties continue to have a large financial stake in the outcome of the case. If Petitioner prevails on the federal question, she will receive a full deduction for her pre-eligibility medical expenses. If Florida prevails, Petitioner's deduction will be limited to less than one-fourth of her medical debt. Florida similarly has a large financial stake with respect to other Floridians similarly situated to Petitioner—i.e., Medicaid beneficiaries in nursing homes to whom Florida refused a deduction for pre-eligibility medical expenses prior to the effective date of the Florida State Plan Amendment.

If the Court does not grant this petition, there will likely be no fix in the near future to the financial harm being visited on Medicaid beneficiaries in nursing homes in the non-compliant states. Despite the broad scope of the problem, vehicles to decide this issue are not abundant. As explained above, many states that fail to comply with federal law do so through low-visibility policies, such as sub-regulatory

handbooks or a followed practice. By using such policies, rather than proposing limits in State Plan Amendments that CMS must approve, states make it difficult for CMS itself to enforce compliance. Private enforcement is also challenging. Providers with the means to challenge state Medicaid policies that harm them and their patients are often unable to bring such challenges in court, s*ee, e.g.*, *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378 (2015), and lawsuits on behalf of beneficiaries can be similarly unavailing, *see, e.g.*, *Martes v. Chief Exec. Officer of S. Broward Hosp. Dist.*, 683 F.3d 1323 (11th Cir. 2012) (holding that Medicaid beneficiaries could not sue under § 1983 to enforce a provision of the Medicaid Act because it did not contain unambiguous rights-creating language). Direct administrative challenges, as in the present case, are also scarce. Many nursing-home residents do not know their rights under federal law, or the manner in which their cost-sharing obligation is calculated. And even when they do, they often lack the resources necessary to effectively fight this practice, as the population affected is by its nature low-income, vulnerable, and with limited access to counsel and to administrative and judicial review.

In the rare instances that states have been called to account for non-compliant policies, some have simply changed their strategies rather than continue to litigate over whether federal law permits them to refuse deductions for pre-eligibility medical expenses. In *In re Brett*, 93 A.3d 120 (Vt. 2014), for example, Vermont initially refused to deduct certain medical expenses on the basis that they were "potentially coverable" by Medicaid, even though they were "not in

fact covered under the program." *Id.* at 126. The Vermont Supreme Court explained that, if Vermont continued to press this interpretation, its Medicaid program "would likely be out of compliance with the applicable federal law on the subject, as interpreted by CMS"—specifically, 42 U.S.C. § 1396a(r)(1)(A). *Id.* at 127. Rather than do so, Vermont changed its position and argued instead that the services at issue were not medically necessary, and therefore the state need not deduct the expenses for them. *See id.* In *Miller ex. rel. Morrish v. Olszewski*, No. 09-13683, 2009 WL 5201792 (E.D. Mich. Dec. 21, 2009), plaintiffs sued Michigan over its policy of refusing to deduct pre-eligibility medical expenses for services not compensable under Michigan's Medicaid program. Rather than defend its policy, which CMS had informally disapproved, Michigan proposed a State Plan Amendment that would permit nursing-home residents to deduct three months of pre-eligibility medical expenses. *See id.* at *5–8. The federal district court therefore did not decide the legality of Michigan's policy, as it instead granted Michigan's request to stay the litigation to allow CMS to consider the State Plan Amendment. *See id.* at *11.

This case may present the only opportunity for this Court to establish uniformity in the Medicaid program and provide the financial relief to which nursing-home residents are entitled under federal law.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for a writ of certiorari.

Respectfully submitted,

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March 7, 2017

APPENDIX

APPENDIX A

IN THE DISTRICT COURT OF APPEAL FIRST DISTRICT, STATE OF FLORIDA

GABRIELLE GOODWIN,

Appellant,

v.

FLORIDA DEPARTMENT OFCHILDREN AND FAMILIES AND DONNA ANSLEY,

Appellees.

NOT FINAL UNTIL TIME EXPIRES TO FILE MOTION FOR REHEARING AND DISPOSITION THEREOF IF FILED

CASE NO. 1D12-4430

_____/

Opinion filed April 4, 2016.

An appeal from State of Florida Department of Children and Families, Office of Appeal Hearings. Susan Dixon, Hearing Officer.

Christine Davis Graves, Robert W. Pass, Martha Harrell Chumbler of Carlton Fields Jorden Burt, P.A., Tallahassee, and Cyril V. Smith and William K.

Meyer of Zuckerman Spaeder LLP, Washington, for Appellant.

Rebecca A. Kapusta, General Counsel, Herschel C. Minnis, Assistant General Counsel, Department of Children and Families, for Appellees.

OSTERHAUS, J.

Gabrielle Goodwin appeals the co-payment calculation made by the Florida Department of Children and Families (DCF) related to her Medicaid-covered nursing home care. She claims that federal law required the agency to deduct all unpaid nursing home bills she incurred before becoming Medicaid eligible from co-payment amounts she was responsible to pay after joining the program. A DCF hearing officer rejected her argument below. And we affirm because DCF reasonably interpreted and applied the Medicaid law upon which Ms. Goodwin bases her challenge.

I.

Ms. Goodwin entered a skilled nursing facility in Tallahassee after a serious accident injured her spinal cord. She applied for Institutional Care Program (ICP) benefits through Florida's Medicaid program to help cover her nursing home costs. She became eligible in March 2012, retroactive to December 2011.

The federal and state government jointly manage Florida's Medicaid program. See Title XIX of the Social Security Act ("The Act"), 42 U.S.C. § 1396a, et seq.; Harris v. McRae, 448 U.S. 297, 308 (1980); Lutheran Servs. Fla. Inc. v. Dep't of Children &

Families, 2015 WL 7566262 (Fla. 2d DCA 2015). At the federal level, the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) oversees state Medicaid programs. In Florida, the Agency for Health Care Administration (AHCA) administers the Medicaid program, while DCF determines eligibility determinations and calculates participants' co-payment amounts. See § 409.902, Fla. Stat. (2011); Fla. Admin Code R. 65A-1.7141. The agencies set forth the operative terms of Florida's Medicaid program, its scope, services, eligibility, and reimbursement policies, in a "State Plan" that CMS approves. 42 C.F.R. § 430.10 (2012).

Beneficiaries in Florida's ICP must contribute to the cost of their care by remitting a monthly co-pay, called a patient responsibility amount (PRA), based on their income. § 409.904(3), Fla. Stat. (2011). Federal Medicaid law instructs the states how to calculate PRAs. The formula begins with the beneficiary's income, but allows for certain deductions, including unpaid medical care expenses. See 42 U.S.C. § 1396a(r)(1)(A); 42 C.F.R. § 435.725(c)(4)(ii) (2012). See also Fla. Admin Code R. 65A-1.7141(1)(g). The program then covers the difference between a beneficiary's PRA and the facility's monthly charge. See § 409.905(8), Fla. Stat. (2011). The smaller the PRA, the greater a beneficiary's Medicaid benefit.

In this case, DCF calculated Ms. Goodwin's PRA at roughly $1000 a month, inclusive of deductions. Ms. Goodwin disputed the calculation. She argued that DCF should have deducted all of her unpaid, pre-eligibility nursing care expenses, lowering her PRA.

She asked DCF to recalculate it, deducting approximately $70,000 of these expenses incurred from November 2010 to November 30, 2011. But DCF disagreed with her legal interpretation and refused to recalculate.

Ms. Goodwin appealed to DCF's Office of Appeal Hearings. She submitted a one-page memorandum arguing that § 1902(r)(1)(A) of the Social Security Act, 42 U.S.C. §1396a(r)(1)(A)(iii), required DCF to deduct her outstanding, uncovered nursing home bills from her PRA. She also alleged that the State Plan didn't authorize DCF's methodology, and that it was "the [only] mechanism through which the State could place reasonable limits on the amount of expenses it deducted from the [PRA]." Both parties waived a hearing and the hearing officer issued a Final Order in August 2012. The Order concluded that the federal statute did not require DCF to deduct all of Ms. Goodwin's pre-eligibility nursing home expenses from her PRA because they were "Medicaid compensable" and "non-recurring" expenses.

Ms. Goodwin timely appealed the Final Order to this court in 2012. But then she quickly moved to stay her appeal two days after filing a class action lawsuit in circuit court. Her class action case raised the same claim and proposed a class of Medicaid recipients in nursing homes for whom DCF had not deducted unpaid, pre-eligibility medical expenses. DCF did not object to a stay, and our court granted it in October 2012.

The stay remained in place for two-and-a-half years until May 2015, when the circuit court denied

Ms. Goodwin's second motion to certify the class.[1] DCF then moved to dismiss this appeal prior to briefing because Florida amended its Medicaid State Plan during the interim stay period to authorize DCF to deduct three months of pre-eligibility medical expenses from PRAs. And DCF subsequently recalculated Ms. Goodwin's PRA with this deduction, which DCF claimed mooted the appeal. But Ms. Goodwin disagreed, insisting that the Medicaid law required DCF to deduct *all* of her medical expenses, or almost a full year of additional expenses. This court denied the motion to dismiss, and her appeal proceeded apace.

II.

Ms. Goodwin argues that DCF's failure to deduct all of her pre-eligibility nursing home bills from her Medicaid co-payment violates federal law, 42 U.S.C. § 1396a(r)(1)(A). She also claims that the Final Order relied upon a non-applicable state regulation, Rule 65A-1.7141(1)(g)1 of the Florida Administrative Code, and that no administrative rule authorized DCF to limit her PRA deduction.

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[1] An appeal of the circuit court's most recent order denying class certification has been decided concurrently with this case, see Goodwin v. DCF, et al., 1D15-2142, according to the parties' request that the cases travel together.

A.

We review interpretations and conclusions of law de novo and findings of fact underlying agency action for competent, substantial evidence. See § 120.68(7)(b), Fla. Stat. (2003); Jacoby v. Fla. Bd. of Med., 917 So. 2d 358, 359 (Fla. 1st DCA 2005). Because this appeal involves DCF's interpretation of a Medicaid provision susceptible to more than one reading, we are mindful of our responsibility to "give great deference to 'an agency's interpretation of a statute that it is charged with enforcing.'" See Lutheran Servs. Fla. Inc. v. Dep't of Children & Families, 2015 WL 7566262 *4 (Fla. 2d DCA 2015) (citing BellSouth Telecomm., Inc. v. Johnson, 708 So. 2d 594, 596 (Fla. 1998)). And we "will not depart from the contemporaneous construction of a statute by a state agency charged with its enforcement unless the construction is 'clearly unauthorized or erroneous.'" Id. (quoting Level 3 Commc'ns, LLC v. Jacobs, 841 So. 2d 447, 450 (Fla. 2003) and P.W. Ventures, Inc. v. Nichols, 533 So. 2d 281, 283 (Fla. 1988)).

B.

Federal and state Medicaid law establish mandatory PRA deductions. They include unpaid medical care expenses "not covered" under a state's Medicaid plan. The federal statute states:

> 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 or 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.

42 U.S.C. § 1396a(r)(1)(A) (emphasis added). A federal regulation tracks the statute's requirement:

> **(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, * * *
>
> **(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— * * *
>
> **(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.

42 C.F.R. § 435.725(c)(4)(ii) (2012) (emphasis added).

In Florida, DCF promulgated a regulation in 2005, in response to federal law, to address deductions:

> 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: . . .
>
> c. Not be a Medicaid compensable expense.

Fla. Admin Code R. 65A-1.7141(1)(g) (emphasis added). Florida's State Plan, which CMS approved in 2004, likewise provided that cannot deduct services covered and paid by Medicaid.

The parties agree that DCF must deduct unpaid medical expenses, which are not "covered" by Florida's Medicaid program, from PRAs. But they vigorously disagree on the definition of Medicaid "covered" care (or Medicaid "compensable" care as used in Florida's regulation). Appellant defines "covered" care as that for which the ICP actually pays. She argues, as a result, that DCF must deduct all of her unpaid, pre-eligibility nursing home expenses because Medicaid did not pay for them. Her interpretation matches CMS's position in defending a federal lawsuit against the State of Maryland. See Maryland Dep't of Health & Mental Hygiene v.

Centers For Medicare & Medicaid Servs., 542 F.3d 424 (4th Cir. 2008). In that case, the Fourth Circuit deferred to CMS's view that Maryland must deduct unpaid, pre-eligibility nursing home costs because it was a "reasonable interpretation of Congress' intent in enacting § 42 U.S.C. 1396a(r)(1)(A)." Id. at 436.

DCF's defines "covered" care, on the other hand, as medical expenses included in Florida's ICP regardless of whether Medicaid pays them for a particular beneficiary. Florida's Medicaid program routinely includes and covers the nursing home care that Ms. Goodwin received before joining the ICP. Thus, DCF considers them Medicaid-covered expenses.

The Fourth Circuit in the Maryland case considered Maryland's, DCF-like interpretation of "covered" to be reasonable. And it ultimately deferred to CMS's interpretation over the DCF-like interpretation under agency deference principles, because it couldn't determine the statute's true meaning.

> We find that the phrase "not covered under the State plan" is susceptible to more precise definition and open to varying constructions. . . . Congress left an interpretive gap . . . Ultimately, we are not the arbiter of whether Maryland or CMS has correctly interpreted § 1396a(r)(1)(A). * * *
>
> CMS has neither exceeded its administrative authority nor clearly erred in its judgment. Thus, even if we agreed that Maryland's SPA is more

> reasonable, CMS would still prevail because we must defer to its interpretation so long as it is reasonable.

Md. Dep't of Health & Mental Hygiene, 542 F.3d at 434, 436 (citations omitted).

Like the court in Maryland, we also think that the federal statute and regulation can be read in different ways. Both DCF and Appellant reasonably construe "covered," and we too must fall back on agency deference. Here, we defer to DCF's reasonable interpretation and enforcement practice because it is the enforcing agency. Its interpretation of Medicaid law prevails, irrespective of which interpretation we might prefer, because it is reasonable, and not clearly erroneous or contrary to law. See Level 3 Commc'ns, 841 So. 2d at 450; BellSouth Telecomm., Inc., 708 So. 2d at 596.

In ruling for DCF, we find no error in the administrative hearing officer's treatment of the Maryland case below. Appellant argues that CMS's litigation position in Maryland controls and binds DCF's interpretation of "covered" in this case. But Appellant didn't cite Maryland in the administrative appeal proceeding below. She argued only that the federal statute's bare language required DCF to recalculate her PRA. But she needed to argue below that Maryland controls DCF's interpretation before raising it here. See Verizon Bus. Network Servs., Inc. ex rel. MCI Commc'ns, Inc. v. Dep't of Corrs., 988 So. 2d 1148, 1150 (Fla. 1st DCA 2008) ("an issue will not be considered on appeal unless the precise legal

argument forwarded in the appellate court was presented to the lower tribunal.").

What is more, putting preservation aside, Appellant has not explained why CMS's position in the Maryland litigation binds DCF's calculation methodology here. Maryland involved another state's Medicaid program and non-parties to this case. Florida wasn't a party to that case, and CMS isn't a party here. Appellant has cited no federal law, regulation, guideline, or other source purporting to adopt CMS's Maryland litigation position in all states, or in Florida specifically. And we see no basis in Appellant's argument for equating CMS's litigation position in Maryland with an authority binding upon DCF. See, e.g., Heimmermann v. First Union Mortg. Corp., 305 F. 3d 1257, 1262 (11th Cir. 2002) (noting that litigation positions "are the kinds of informal policy positions that lack the force of law and are unentitled to Chevron deference") (citing United States v. Mead Corp., 533 U.S. 218, 234-35 (2001)); William Bros. v. Pate, 833 F.2d 261, 265 (11th Cir. 1987) ("[W]e do not agree that the [agency's] mere litigating position is due to be given deference.").

B.

Appellant's other arguments raise state rule-based concerns. She claims that Rule 65A-1.7141(1)(g) of the Florida Administrative Code doesn't apply here, and that Florida had no rule authorizing DCF to limit PRA deductions when she became eligible for Medicaid. See 42 U.S.C. § 1396a(r)(1)(A) (allowing states to establish reasonable limits on the amount of deductible pre-existing medical expenses).

But once again, Appellant did not preserve the issue. "It is well-established that for an issue to be preserved for appeal, it must be raised in the administrative proceeding." Dep't of Bus. & Prof'l Regulation, Const. Indus. Licensing Bd. v. Harden, 10 So. 3d 647, 649 (Fla. 1st DCA 2009). "[A] party cannot argue on appeal matters which were not properly excepted to or challenged in the administrative tribunal." Pullen v. State, 818 So. 2d 601, 602 (Fla. 1st DCA 2002). Appellant filed a one-page memorandum in the administrative appeal proceeding below challenging DCF's PRA calculation. But her challenge didn't address the applicability of Rule 65A-1.7141(1)(g). Even after DCF cited and relied upon this state rule to defend its PRA calculation methodology, Appellant met the argument below with silence. The Final Order, with no reason to doubt its relevancy, cited and relied upon it.

The rule appears plenty relevant on its face. DCF had promulgated it some six years before Appellant applied for Medicaid to address PRA calculations consistent with federal parameters. It broadly described how DCF should incorporate beneficiaries' pre-eligibility medical expenses into PRAs. And it tracked the federal statute's relevant language regarding deductions for non-compensable expenses: "[I]n accordance with 42 CFR 435.725 . . . [t]he medical/remedial care service or item must . . . [n]ot be a Medicaid compensable expense." Rule 65A-1.7141(1)(g), F.A.C.; see also 42 U.S.C. § 1396a(r)(1)(A) & 42 C.F.R. § 435.725(c)(4)(ii). For these reasons, we find no error in the Final Order relying upon Rule 65A-1.7141(1)(g).

III.

We conclude that DCF need not deduct more from Appellant's PRA than the three months of pre-eligibility nursing home expenses that it has already deducted. The Final Order is AFFIRMED.

THOMAS and BILBREY, JJ., concur.

APPENDIX B

DISTRICT COURT OF APPEAL, FIRST DISTRICT
2000 Drayton Drive
Tallahassee, Florida 32399-0950
Telephone No. (850)488-6151

July 21, 2016

CASE NO.: 1D12-4430
L.T. No.: 12F-02923

Gabrielle Goodwin	v.	Florida Department of Children etc. et al.

Appellant / Petitioner(s),	Appellee / Respondent(s)

BY ORDER OF THE COURT:

Appellant's motion filed April 19, 2016, for rehearing/rehearing en banc is denied.

Appellant's motion filed April 19, 2016, for oral argument on motion for rehearing/rehearing en bane is denied.

I HEREBY CERTIFY that the foregoing is (a true copy of) the original court order.

Served:

Jason Vail
Robert Pass
Teresa L. Mussetto, A. A. G.
Christine Davis Graves
William K. Meyer
Cary L. Moss
Herschel C Minnis
Lauchlln Waldoch
Jana E. McConnaughhay
Rebecca Kapusta
Cyril V. Smith

Lisa Raleigh, A. A. G.
Martha Harrell Chumbler
Michael Lee
Camille Larson
David Hook

jm

/s/ Jon S. Wheeler

APPENDIX C

Supreme Court of Florida

THURSDAY, DECEMBER 8, 2016

CASE NO.: SC16-1542
Lower Tribunal No(s).:
1D12-4430; 12F-02923

GABRIELLE GOODWIN	vs.	FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES, ET AL.
Petitioner(s)		Respondent(s)

This cause having heretofore been submitted to the Court on jurisdictional briefs and portions of the record deemed necessary to reflect jurisdiction under Article V, Section 3(b), Florida Constitution, and the Court having determined that it should decline to accept jurisdiction, it is ordered that the petition for review is denied.

No motion for rehearing will be entertained by the Court. See Fla. R. App. P. 9.330(d)(2).

LABARGA, C.J., and PARIENTE, QUINCE, and PERRY, JJ., concur. LEWIS, J., would grant oral argument.

A True Copy
Test:

/s/ John A. Tomasino
Clerk, Supreme Court

two
Served:

CAMILLE M. LARSON
MARTHA HARRELL CHUMBLER
CARY LEIGH MOSS
ELLEN SUE MORRIS
CHRISTINE DAVIS GRAVES
HERSCHEL C. MINNIS
REBECCA KAPUSTA
ROBERT W. PASS
CYRIL V. SMITH
WILLIAM K. MEYER
HON. JON S. WHEELER, CLERK

APPENDIX D

STATE OF FLORIDA

DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

GABRIELLE GOODWIN
LAUCHLIN WALDOCH, ESQ.
1709 HERMITAGE BL
STE 102
TALLAHASSEE, FL 32308

APPEAL NO. 12F-02923

PETITIONER,

Vs.

CASE NO. 1362242021

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 24, 2012.

APPEARANCES

For the Petitioner: Lauchlin Waldoch, Esq.
Ann Westall, Public Benefit Manager

For the Respondent: Paul Rowell, Esq.
Regional Legal Counsel
Nartasha Peacock, Supervisor
Carrie Sheffield, Management Review Specialist
Medicaid Program Office

Observer: Melissa Roedel, hearing officer

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 19, 2012 which did not address using unmet medical expenses (UME) for services prior to eligibility to reduce the patient responsibility.

PRELIMINARY STATEMENT

Prior hearing dates were scheduled for May 8, 2012 and July 11, 2012. Continuances were granted and the hearing was then set for July 24, 2012. The hearing record was held open through July 27, 2012 for the respondent and through July 31, 2012 for petitioner to file any rebuttals, if needed.

FINDINGS OF FACT

The parties submitted a Joint Stipulation of Summary of Facts Supported by Documents to be included in Evidence; the stipulated facts are cited below in paragraphs one through five:

1. Petitioner is a resident of Heritage Health Care, a skilled nursing facility (the facility) in Tallahassee, Florida; she was admitted in November 2010.

2. The facility applied several times for long term care Medicaid under Florida's Institutional Care Program (ICP) beginning in March 2011; these requests were denied for various reasons.

3. An application for ICP was filed online on January 18, 2012, seeking retroactive coverage effective December 2011. The application also indicated that there were pre-eligibility unmet medical expenses (UME).

4. The Department approved the application and issued notice on March 19, 2012. Benefits were approved retroactive to December 2011.

5. The issue of UME was not addressed in the approval notice. Petitioner's representative sent an email on March 20, 2012 requesting that a nursing home bill for services prior to eligibility be used as a UME in order to reduce the patient responsibility. A copy of the outstanding charges was attached. The Department responded stating, "As you are aware we are not able to do this - our policy on this has not changed."

6. Respondent's Exhibit 2 includes a copy of Florida's State Plan under Title XIX of the Social Security Act, Supplement 3 to Attachment 2.6-A and was approved February 23, 2004. The Supplement 3 is "Post-Eligibility Treatment of Institutionalized Individuals' Incomes" and states, "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: ... 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."

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 Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 652.056.

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

10. Title 42 Section 435.725 C.F.R. states in pertinent part, the following:

> 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...(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 expenses.

11. In accordance with 42 C.F.R. 435.725, Florida Administrative Code 65A-1.7141 pertaining to SSI-Related Medicaid Post Eligibility Treatment of Income was promulgated and states in relevant part:

(1)(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** (emphasis added).

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.

2. For services or items not covered by the Medicaid State Plan, the amount of the deduction will be the actual amount for services or items incurred not to exceed the highest of a payment or fee recognized by Medicare, commercial payers, or any other contractually liable third party payer for the same or similar service or item.

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.** (emphasis added)
> 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)

12. Petitioner argues that Florida is in violation of federal law as §1902(a)(1)(A) of the Act, 42 U.S.C. §1396(a)(1)(A)(iii), requires that states allow a reduction in patient responsibility to account for "necessary and 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." Petitioner believes the State plan would have been the mechanism through which the State could place reasonable limits on the amount of expenses it deducted from the patient responsibility amount.

13. Respondent argues that the law allows for reasonable limits to be set by each state on the amount of expenses to be deducted form the ICP patient responsibility. Florida devised a state plan which was approved by Centers for Medicare and Medicaid Services (CMS) which excludes payments for those services paid for by Medicaid. Respondent argues that the Department applies a liberal interpretation of the federal statute and the federal regulation which states "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." In creating and obtaining approval of its state plan, Florida is in compliance with Federal and State law and is no more restrictive than the statute and regulations permit.

14. The federal and state authorities specifically state that deductions may be used for health insurance payments, premiums, deductibles and coinsurance charges. The undersigned concludes that 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 responsibility. The undersigned concludes that if the ongoing patient responsibility was reduced due to nursing home expenses prior to becoming ICP eligible, Medicaid would be paying a larger share of the ongoing care in the facility due to a past period of time when petitioner was not eligible 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. The undersigned concludes that the Department correctly excluded petitioner's nursing home expenses prior to becoming Medicaid eligible,

in the ongoing ICP patient responsibility determination, based on the limits Florida chose and the Federal CMS agency approved. The limits to incurred medical expense deductions recognized in post-eligibility treatment of institutionalized individuals' incomes include services and items paid for under the Medicaid State Plan and Services and items covered by and paid for under the Medicaid nursing or other facility per diem. In addition, the Florida Administrative Code clarifies that the expense used as a deduction to the patient responsibility cannot be a Medicaid compensable expense. Nursing home room and board charges are Medicaid compensable expenses.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

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 16th day of August, 2012 in Tallahassee, Florida.

/s/ Susan Dixon
Susan Dixon
Hearing Office
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: GABRIELLE GOODWIN,
Petitioner
2 DPOES: Reg Altazan
Paul Rowell, Esq.

APPENDIX E

42 C.F.R. § 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,

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) Applicability. This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional

status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(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 beneficiaries 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.

(5) Continued SSI and SSP benefits. The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) Optional deduction: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if --

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if --

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) Determination of income --

(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses --

(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

APPENDIX F

Fla. Admin. Code Ann. r. 65A-1.7141 (2005)

SSI-Related Medicaid Post Eligibility Treatment of Income.

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.

(b) If the individual earns therapeutic wages, an additional amount of income equal to one-half of the monthly therapeutic wages up to $111 shall be protected for personal need. This protection is in addition to the $35 personal need allowance.

(c) Individuals who elect Hospice service have an amount of their monthly income equal to the federal poverty level protected as their personal need allowance unless they are a resident of a medical institution, in which case $35 of their income is protected for their personal need allowance.

(d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the

institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current Food Assistance Program standard utility allowance is used to determine the community spouse's excess utility expenses.

(e) For community Hospice cases, a spousal allowance equal to the SSI Federal Benefit Rate (FBR) minus the spouse's own monthly income shall be deducted from the individual's income. If the individual has a spouse and a dependent child(ren) they are entitled to a portion of the individual's income equal to the Temporary Cash Assistance consolidated need standard (CNS) minus the spouse and dependent's income. For CNS criteria, refer to subsection 65A-1.716(1), F.A.C.

(f) For ICP or institutionalized Hospice, income is protected for the month of admission and discharge, if the individual's income for that month is obligated to directly pay for their cost of food or shelter outside of the facility.

(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.

2. For services or items not covered by the Medicaid State Plan, the amount of the deduction will be the actual amount for services or items incurred not to exceed the highest of a payment or fee recognized by Medicare, commercial payers, or any other contractually liable third party payer for the same or similar service or item.

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.

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).

6. The initial projection period is the first day of the first month of Medicaid eligibility beginning no earlier than the application month through the last

day of the sixth month following the month of approval. A semi-annual review is scheduled for the fifth month after the month approved to evaluate the recipient's actual incurred medical expenses for the prior six months.

7. For the semi-annual review, the department will request documentation of the recipient's actual incurred medical expenses for the prior six months.

a. If the recipient documents their actual expenses, staff must compare the total projected expenses budgeted with the total actual recurring expenses to determine if the projection was accurate. If the projection was overstated or understated by more than $120, the department must use the amount overstated or understated by more than $120 combined with the total expenses anticipated to recur and any non-recurring expenses incurred during the period to compute an average amount to deduct from patient responsibility for the next projection period, if possible. If an adjustment is not possible, the department must adjust the patient responsibility for each past month in which an expense was overstated.

b. If a recipient fails to document their actual expenses for the last projection period at the time of their semi-annual review, the department must assume the recipient did not incur the expense(s) which was projected. The department will remove the deduction for the next projection period and calculate the total amount of deductions incorrectly credited in the prior projection period to adjust the recipient's future patient responsibility. If an adjustment is not possible, the department must adjust the patient responsibility for each past month in which an expense was overstated.

8. The steps in subparagraph (g)7. above must be repeated for each semi-annual review.

9. Recipients must report their uncovered medical expenses timely.

a. New, recurring uncovered medical expenses must be reported no later than the tenth day of the month in which the next semi-annual review is due. If the due date falls on a weekend or holiday, the recipient must report by the end of the next regularly scheduled business day. Recurring expenses reported timely will be included in the calculation of patient responsibility beginning with the month the expense was incurred. Recurring expenses not reported timely will be included in the calculation of patient responsibility beginning the month reported and will be prorated for the remaining months of the projection period, but no adjustments in patient responsibility will be made for past months in which expenses went unreported.

b. Non-recurring uncovered medical expenses must be reported no later than the tenth day of the month in which the next semi-annual review is due. If the due date is a weekend or holiday, the recipient must report by the end of the next regularly scheduled business day. Non-recurring expenses reported timely will be held until the semi-annual review month and prorated over the next six-month period. Non-recurring expenses not reported timely will not be included as a deduction in the patient responsibility calculation.

(2) For ALW/HCBS, the following deductions shall apply in computing patient responsibility:

(a) An allowance for personal needs in the amount

equal to the Optional State Supplementation (OSS) (as defined in Chapter 65A-2, F.A.C.), cost of care plus the OSS personal need allowance.

(b) An amount equal to the cash assistance consolidated need standard minus the dependent's income for the client's dependent unmarried child under age 21 or their disabled adult child living at home, when there is no community spouse.

(c) Deductions in paragraphs (1)(b), (d), (f) and (g) as applicable.

Rulemaking Authority 409.919 FS. Law Implemented 409.902, 409.903, 409.904, 409.906, 409.919 FS. History–New 5-29-05.

APPENDIX G

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the matter of:

The Disapproval of the Maryland State Plan Amendment	Docket No. SPA-05-06

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for final agency review pursuant to 42 CFR 430.102. The State requested that the Administrator reconsider the issue of whether the State Plan Amendment (SPA) 05-06 conforms to the requirements for approval. The Hearing Officer's recommended decision was issued January 31, 2007, affirming the disapproval of SPA 05-06. The State filed timely exceptions, requesting that the Administrator approve the SPA 05-06. Accordingly, this case is now before the Administrator for final administrative action.

ISSUE

The issue is whether CMS' denial of Maryland's proposed amendment to its State Medicaid Plan was proper.

BACKGROUND

In 2005, the Maryland Department of Health and Mental Hygiene (State) submitted SPA 05-06 to CMS for review. The SPA was entitled "reasonable limits on amounts for necessary medical and remedial care not covered under Medicaid.[1] CMS confirmed, through consultation with the State, that the State intended to limit the deduction of medical expenses in the post-eligibility process to only those expenses incurred during a period of eligibility for Medicaid. CMS considered the State's treatment of medical expenses in the post-eligibility process more restrictive than under the spend-down procedure. The CMS Administrator disapproved SPA 05-06.

The Administrator found that §1902 (r)(1)(A) of the Act requires States to take into account, under the post-eligibility process, amounts for incurred medical and remedial care expenses that are not subject to payment by a third party. Further, that section permits States to place reasonable limits on the amount of necessary medical and remedial care expenses recognized under State law, but not covered under the State plan. However, those reasonable limits must ensure nursing home residents are able to use their own funds to purchase necessary medical or remedial care not covered, i.e. not paid for, by the State Medicaid program. The Administrator concluded that it would not be reasonable "to exclude from post-eligibility protection an incurred medical expense that could be deducted from a person's

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[1] Maryland's Brief in Support of Approval of Maryland SPA No. 05-06, Exhibit 4.

income under the medically needy spend-down process."

Similarly, the Administrator found that it would be unreasonable to recognize an expense for purposes of the spenddown process, but not to deduct that same expense from an individual's income for purposes of calculating the contribution to the post-eligible cost of care. The Administrator concluded that, while States may establish reasonable limits on the amount of non-covered services, such a proposed limit is not reasonable if the result were to deny the individual the ability to pay for a non-covered expense used to establish eligibility during a budgeted period.

The Administrator noted that § 1902(r)(1) of the Act, as originally enacted, repealed revised post-eligibility regulations promulgated by the Secretary in February 1988. The legislation reinstated the policies set forth in previous regulations. Congress specifically rejected the revised regulations which would have given the State the authority to implement the limits proposed here.

The Administrator found that by not protecting income to pay for non-covered expenses which were used to establish eligibility under the medically needy spenddown provision, the State proposed amendment undercuts the Medicaid statute's purpose of requiring the State to deduct incurred expenses under the spenddown process. Therefore, the Administrator found that such a proposal was not reasonable. As a result, the Administrator found that the State's limit does not meet the requirement of §1902(a)(17) of the Act, as refined by §1902(r)(1) of the Act. For individuals whose

post-eligibility calculation is determined using spousal impoverishment rules, specified at §1924 of the Act and refined by §1902(r)(1) of the Act, the Administrator found that the limit does not meet the requirements of §1902(a)(51) of the Act (which requires the State plan to meet the requirements of §1924 of the Act).

The State filed a timely Petition for Reconsideration pursuant to 42 CFR 430.18. The issues to be considered during the hearing were whether the amendment's limit violated the requirements of §§ 1902(a)(17) and 1902(a)(51) of the Act by imposing an unreasonable limit on expenses for medical and remedial care which would be protected under the post-eligibility process.

Pursuant to 42 CFR 430.76(c)(3), several individuals, States and organizations petitioned for, and were granted permission, to participate as amicus curie in the proceedings.

HEARING OFFICER'S RECOMMENDED DECISION

The Hearing Officer's recommended decision stated that CMS holds the authority to oversee the standards that States develop for their medical assistance program and that CMS operated within its legislative mandate when it established the policy that requires consistent treatment of incurred expenses in the spend-down and post-eligibility process. Therefore, Maryland's SPA 05-06 is inconsistent with the CMS policy and was properly denied.

SUMMARY OF EXCEPTION REQUEST

The State submitted an exception which challenged many aspects of the Hearing Officer's recommended decision and reiterated its legal arguments to support its request for the SPA 05-06's approval. The State challenged CMS' legal authority to prescribe "reasonable limits" applicable to the post-eligibility deduction in the form of an expansion of Medicaid eligibility. The State also argued that the CMS' policy for applying spend-down limits to post-eligibility has no basis in the legislative history, or statutory provisions.[2]

DISCUSSION

The entire record, which was furnished by the Hearing Officer, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Hearing Officer's decision. All exceptions received timely are included in the record and have been considered.

Title XIX of the Act provides for joint Federal and State financing of medical assistance for persons whose income and resources are insufficient to meet the costs of necessary care and services.[3] Section 1905(a) of the Act defines medical assistance as the payment of part or all of the cost of certain medical care and services. In return, participating States must

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[2] CMS submitted an untimely response to the State's exception request to the proposed Hearing Officer's decision which were not considered or included in the record.

[3] 42 U.S.C. §§ 1396 *et seq.*.

comply with requirements imposed by the Act and by the Secretary of Health and Human Services.[4] States are required to submit a State plan for medical assistance to the Secretary of the Department of Health and Human Services for approval. The State plan reflects the State's choices as to the medical assistance it offers different categories of recipients. A State plan must meet the statutory and regulatory requirements set forth in Title XIX and at 42 CFR 430, et seq.

The Medicaid statute requires States participating in the program to provide coverage to the "categorically needy", i.e., those individuals with incomes low enough to qualify to receive cash assistance.[5] The statute also permits States to elect to provide medical benefits to the "medically needy", i.e., persons who meet the non-financial eligibility requirements for cash assistance, but whose income or resources exceed the financial eligibility standards for those programs. Under §1902(a)(17)(D), the medically needy may qualify for Medicaid if they incur medical expenses in an amount that effectively reduces their income to the eligibility level. This provision is called the "spenddown" and recognizes that when medically needy individuals pay the amount by which their income exceeds medically needy levels they are in the same position as persons eligible for cash assistance.[6]

Section 1902(a)(17) of the Act states in part that a State Plan for medical assistance must include reasonable

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[4] § 1902 of the Act.

[5] *See §* 1902(a)(10)(A) of the Act.

[6] *See* Atkins v. Rivera, 106 S. Ct. 2456, 2458-59 (1986).

standards for determining eligibility for, and the extent of, medical assistance under the plan which, under paragraph (D), in part, provides:

> [F]lexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs ... incurred for medical care or any other type of remedial care recognized under State law.

Consistent with the authorities granted to the Secretary under §1902(a)(17), the Secretary promulgated the regulations at 42 CFR 435.831 which set standards for determining income eligibility for medically needy individuals. The regulations require that States first determine an individual's countable income by subtracting from his/her income amounts that would be subtracted to determine eligibility for cash assistance. If the individual's countable income exceeds the Medicaid standard, States must then deduct incurred Medical expenses.

With respect to the spenddown provision, prior to 1994 the States were required to deduct all medical expenses incurred before application, no matter how far back in time the expenses were incurred if they had not already been used in another budget period, if the individual was still liable for them, or if the individual had paid for them in the current budget period.[7] In 1994, the Secretary revised the regulations

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[7] 59 Fed. Reg. 1659, 1666 (January 12, 1994) ("Medicaid Program; Deductions of Incurred Medical Expenses (Spenddown.").

to require that States deduct only current medical expenses, those incurred within three months prior to the month of application, and current payments on bills more than three months old. The revisions allowed States to deduct medical expenses incurred more than three months prior to the month of application, and on which the individuals made no payments in the current budget period but the revision did not make the deduction a requirement.[8]

The Secretary considered the three-month limit "reasonable" because it afforded some administrative relief to the state while recognizing that individuals may remain liable for old bills. The Secretary also considered the three-month limit consistent with the limits set by the Congress for the States to provide medical assistance in §1902(a)(34) and, therefore, a suitable guideline for determining how far back the States should account for incurred health costs.[9]

The revised regulations at 42 CFR 435.831 requires States to deduct expenses incurred during or after the three-month retroactive period for all medical and remedial services recognized under State law, whether or not such services are included in the State's plan and whether or not such expenses exceed State limitations on the amount, duration or scope of services. If, after deduction such medical expenses, the individual's remaining income falls below the Medicaid income standard, the individual is eligible for Medicaid. However, he/she remains responsible for

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[8] 42 CFR 435.831(f) and (g).

[9] 59 Fed. Reg. 1659, 1666.

paying any expenses deducted in the spenddown process.

In revising the spenddown regulation in 1994 with respect to incurred expenses, the Secretary ultimately rejected a proposal to allow States to limit deductible medical expenses to services "covered under the State plan." The Secretary noted that:

> We now believe that offering States this administrative option would reduce a person's Medicaid eligibility or the amount of medical assistance provided. Further, Congress passed legislation in 1988 amending the Social Security Act (section 1902(r)(1)) to override a similar option we provided States in the post-eligibility process. We believe it would be inconsistent with the direction taken by Congress in the post-eligibility process to allow a similar limitation in the spenddown process.[10] (Emphasis added.)

Likewise, when discussing deductibles and coinsurance in the spenddown process, the Secretary again recognized the inter-connection and consistency between the spenddown policy and the post-eligibility policy, stating that:

> Congress passed legislation on the post-eligibility process requiring the deduction of expenses for deductibles

[10] 59 Fed. Reg. 1659, 1670.

> and coinsurance in the post-eligibility process. It would be inconsistent with the direction taken by Congress to allow States to exclude these expenses in the spenddown process altogether. Therefore, States are required to deduct a reasonable amount of these expenses from income.

Regarding the post-eligibility process, Medicaid requires recipients who are nursing home residents to contribute a portion of their income to the cost of their care.[11] To ensure that nursing home residents pay for their care to the extent that they are capable, the Medicaid statute and regulations require States to perform a second calculation for institutionalized individuals. The calculation is called the post-eligibility contribution to care and permits Medicaid to determine the extent of Medicaid's payment for medical assistance for institutionalized individuals.

Prior to 1988, the Secretary had implemented rules making post-eligibility deductions for medical expenses for services not covered under the State plan mandatory. However, the Secretary published a final rule in 1988 that allowed States to disregard income needed to cover expenses incurred for necessary medical and remedial care recognized under State law but "not covered in the State Medicaid plan." [12] Generally, the Secretary proposed to allow States to disregard incurred expenses for services not covered

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[11] §1902(a)(17) of the Act.

[12] 53 Fed. Reg. 3586 (Feb 8, 1988) ("Medicaid Program Payments to Institutions").

under the plan, i.e., where "no payment is made for them."[13] The rule addressed States' complaints that deducting medical expenses not covered under the State plan produced an indirect subsidy of services that the State had determined not to cover. The Secretary specifically addressed comments regarding medical expenses incurred during a period of ineligibility in the context of the phrase "not covered' under a State plan. Specifically, the Secretary stated that:

> Several commenters suggested that we revise the regulations to place limits on medical deductions for expenses incurred during a period of ineligibility. One of these commenters argued that deductions should be permitted only for services furnished within a budget period. Otherwise, a State is subsidizing medical expenses for a period during which an individual was ineligible. The second commenter asked if States may limit the amount of deductions for institutional expenses during periods of ineligibility to no more than the Medicaid reimbursement rate. A third commenter asked for specific examples of limits or parameters in guidelines.
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> Response: Services furnished to an individual during a period of ineligibility are services not covered under the State plan. Therefore, the

[13] 53 Fed. Reg. 3586 at Subsection B.

> State is not required to deduct medical expenses for services furnished during a period of ineligibility, and may limit deductions to services within the budget period. If the State chooses to allow deductions for medical expenses furnished during a period of ineligibility, it may place reasonable limits on these deductions. This includes institutional expenses incurred during a period of ineligibility and expenses for other covered services. States have the option to deduct institutional expenses at the private rate or at the Medicaid reimbursement rate, subject to reasonable limits imposed by the State.[14] (Emphasis added.)

However, Congress intervened before the rule became final by adding paragraph (r) to §1902 of the Act.[15] Congress ratified the Secretary's prior regulatory language by incorporating this language in the statute. Congress thereby rejected the Secretary's proposal to make these deductions optional including making optional deductions for services not covered by a State plan that were incurred during a period of ineligibility. In particular, §1902(r)(1) states that:

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[14] 53 Fed. Reg. 3586 (February 8, 1988).

[15] Section 303(d) of the Medicare Catastrophic Coverage Act of 1988 (MCC) amended section 1902 of the Act to add a new subsection (r); redesignated as (r)(1) by § 303(e)(5) of the MCC.

> (r)(1)(A) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915 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, ..., 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 title, subject to reasonable limits the State may establish on the amount of these expenses.... (Emphasis added.)

Congress enacted this provision to protect institutionalized individuals and ensure that they were "able to use their own funds to purchase necessary or remedial care not covered by the State Medicaid program."[16] When Congress ratified this

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[16] H.R. Conf. Rep. 100-661, 1988 U.S.C.C.A.N. 923, 1044.("The conferees note that until recently, HCFA regulations required that Medicaid—eligible nursing home residents be allowed to deduct uncovered medical costs from their income before contributing towards the cost of nursing care. However, a recent HCFA regulation, 53 *Fed. Reg.* 3586 (Feb 8, 1988), altered this

language, the Secretary reasonably concluded that Congress was ratifying the Secretary's interpretation of "services not covered under a state plan" as including medical expenses incurred during a period of ineligibility.

The regulatory language that pre-dates the enactment of §1902(r) (1) of the Act is set forth at, among other places, 42 CFR 435, subparts H and I which address both the categorically needy and medically needy post-eligibility rules. The regulations at 42 CFR 435.832 and 436.725, inter alia, require States to determine the extent of Medicaid's payment by deducting certain expenses from an institutionalized person's income. The regulations at 42 CFR 435.725 and 42 CFR 435.832 similarly state that:

> 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.
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> ****
>
> (4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that

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rule to allow Stats to limit this deduction substantially, or to eliminate it altogether. The conference agreement is intended to reinstate the previous rule, retroactive to the effective date of the recent change ...." (Emphasis added.)

> 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.... (Emphasis added.)

States are required to deduct a personal needs allowance, spousal and family maintenance allowances and certain incurred medical expenses. States may elect to deduct other specified expenses in addition to these required deductions. For medical expenses not subject to payment by a third party, States must deduct "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 the amounts of these expenses.[17] Once the deductions are made, Medicaid assumes that an individual can use the remaining income to pay for his/her own care and that amount is deducted from the payment that Medicaid makes to the institution.

Section 1902(a)(17) of the Act requires that State plans include reasonable standards to determine eligibility for, and the extent of, medical assistance taking into

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[17] 42 CFR 435.725(c)(4)(ii).

account only the costs incurred for medical or remedial services recognized under state law, except to the extent prescribed by the Secretary. The Secretary has delegated his authority to administer the Medicaid program to the Administrator of CMS. The Administrator has determined that States are required to treat incurred medical expenses consistently in both the spenddown and post-eligibility processes.[18] The Secretary explicitly stated in 1988 that "services not covered under a State plan" includes services furnished to an individual during a period of ineligibility. Thus, when Congress reinstated the rule requiring that States deduct necessary medical or remedial care recognized under State law "but not covered under the State's Medicaid plan", the Secretary reasonably concluded that Congress reinstated the Secretary's policy with respect to post-eligibility treatment of costs for services incurred during a period of ineligibility.

The Secretary's policy reasonably treats expenses for medical or remedial care incurred in the period prior to eligibility as "not covered under the State plan." The policy recognizes that the intent of §1902(r)(1) of the Act in refining §§1902(a)(17) and 1902(a)(51) of the Act (in reference to §1924) is to afford an institutionalized individual with income the ability to pay non-covered medical expenses for medical or remedial care. Failure to protect income to pay for non-covered expenses which were used to establish

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[18] The Supreme Court considers §1902(a)(17) and "explicit grant of rulemaking authority" and affords "legislative effect" to regulations that the Secretary adopts pursuant to its authority. Atkins v. Rivera, supra, 106 S. Ct. at 2461.

eligibility under the medical needy spend down, would undercut the purpose of requiring States to deduct incurred expenses under the spend down provisions. As the State Plan amendment fails to protect income to enable the individual to actually pay for these incurred expenses, the State's proposed limit is not reasonable. The Maryland SPA 05-06 which allows that deduction in the post-eligibility program process only if an individual is eligible for Medicaid during the period is inconsistent with the CMS policy. In light of the foregoing, the Administrator finds that CMS' denial of Maryland SPA 05-06 was proper.

DECISION

Accordingly, the Administrator adopts the Hearing Officer's decision and affirms CMS' disapproval of the Maryland SPA-05-06.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: /s/ 3/28/07

/s/ Herb B. Kuhn
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare &
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APPENDIX H

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MEMORANDUM

TO: Brad Nye, Assistant Director, DAAS
Jack Tiner, DAAS

FROM: Richard Rosen, Attorney

DATE: April 19, 2016

RE: Post Eligibility Income Offset

This responds to your inquiry regarding a post eligibility income offset for nursing home expenses incurred during a period when the applicant was not eligible for LTC medical assistance or had not applied for such assistance. The recipient, through counsel, seeks an offset of $15,046.48 for nursing home costs incurred prior to the recipient's eligibility determination. The income offset sought is to pay the recipient's nursing home costs for the period of April, 2012 through August, 2012. Per the information provided, the recipient was determined to be eligible for LTC assistance on August 14, 2012.

LTC medical assistance is a means tested program. In order *be* eligible, an applicant must first meet certain income and resource restrictions. Once these

limitations and all other requirements are meet, a recipient is then required to contribute his/her monthly income to the cost of care, except that certain unpaid medical expenses not covered by the Arkansas State Plan may be paid from the recipient's income. *See* MS H-410. Medicaid then pays the balance of the monthly nursing home charges. Among the deductions from income allowed by MS H-410 are necessary medical expenses not covered under the State Plan. Id.

MS H-410 is consistent with the authority provided in the Arkansas State Plan, Attachment 2.6A, Page 4a, effective 12-01-1998. Like MS H-410, the State Plan provides for an income offset for necessary medical expenses not covered under the Plan. Because nursing facility payments are expenses covered by the State Plan for otherwise eligible individuals, such expenses are not subject to the income offset provisions for any period of time where the recipient was not otherwise determined eligible. Consequently, it is my opinion that nursing home expenses incurred prior to an individual's eligibility determination are not subject to income offset.

It is also my opinion counsel's claim about the State Plan's lack of reasonable limitations on the amount of potential offsets is premature and not relevant to the threshold issue of whether the expense is even subject to any such offset. Medicaid does not seek to limit the amount of any income offset here because no such offset is allowed.

If you have any questions, please call me at 501/ 320-6334.

APPENDIX I

Before the Office of Appeals and Hearings
State of Arkansas

Velma Martindale **Petitioner**

v. **Case No. 20163249**

Arkansas Department of Human Services **Respondent**

Response to Petitioner's Brief

Comes now the Respondent, Arkansas Department of Human Services, by and through its attorney, Nick R. Windle, and for its Response to Petitioner's Brief, respectfully states as follows:

Introduction

Prior to being approved for long-term care Medicaid, the Petitioner's initial application was denied. During her period of ineligibility, the Petitioner incurred $15,046.48 in nursing home costs. The Petitioner's post-eligibility request to offset her income was denied based on DHS's long-standing interpretation of "not covered under the State Plan" as the term appears in 42 U.S.C. § 1396a(r)(1)(A)(ii) and as it relates to MS § H-410 and the State Plan. Specifically, the position of DHS is that nursing home costs incurred prior to an individual's eligibility are not subject to income offset. This interpretation is reasonable as the alternative interpretation asserted by the Petitioner would result in Medicaid essentially covering costs for a

time period in which the Petitioner was not eligible for long-term care Medicaid.

Issue

As noted by the Petitioner, the issue in this case is whether the language in 42 U.S.C. § 1396a(r)(1)(A)(ii) pertaining to expenses "not covered under the State Plan" includes pre-eligibility nursing home costs. The Petitioner argues that, since Medicaid did not cover her pre-eligibility nursing home costs, these qualify as expenses "not covered under the State Plan" per 42 U.S.C. § 1396a(r)(1)(A)(ii), and she should be able to deduct these costs from her post-eligibility income. The position of DHS is that, since nursing home costs are expenses covered by the State Plan for otherwise eligible individuals, pre-eligibility nursing home costs are not expenses "not covered under the State Plan."

Petitioner's Argument

A large portion of Petitioner's brief is a recitation of the history of the Medicaid program and the post-eligibility provision. The Petitioner then moves on to her substantive arguments which are based primarily on one Fourth Circuit case - *Md. Dep't of Health and* Mental *Hygiene v. Ctrs. for Medicare and Medicaid Servs.*, 542 F.3d 424, 429 (4th Cir. 2008). In that case, the Maryland Department of Health and Mental Hygiene ("Maryland") filed a petition to review CMS's rejection of an amendment to the Maryland State Medicaid Plain. *Id.* at 426. Specifically, in that case, CMS took a position on post-eligibility deductions that mirrored the position taken by the Petitioner in the case at hand. When Maryland challenged this position, the court denied

Maryland's petition, stating that the term "not covered under the State Plan" is ambiguous and that CMS's interpretation of that term was reasonable. *Id.*

The Petitioner's argument can be summed up as follows: (1) the term "not covered under the State Plan" as it appears in 42 U.S.C. § 1396a(r)(1)(A)(ii) is ambiguous; (2) in *Md. Dep't of Health and Mental Hygiene,* CMS took the position that pre-eligibility nursing home costs are "not covered under the State Plan;" and (3) CMS's position in *Md. Dep't of Health and Mental Hygiene* is controlling and should determine how DHS interprets and applies 42 U.S.C. § 1396a(r)(1)(A)(ii).

Response

It is clear that CMS took the position in *Md. Dep't of Health and Mental Hygiene* that this term included pre-eligibility nursing home costs. However, CMS's litigation position in the *Md. Dep't of Health and Mental Hygiene* case is not controlling as to how DHS interprets and applies 42 U.S.C. § 1396a(r)(1)(A)(ii).

In support of this position, DHS notes: (1) the most recent court to consider the Petitioner's position rejected the argument that *Md. Dep't of Health and Mental Hygiene* was controlling and deferred to a state's interpretation of "not covered under the State Plan" which mirrors DHS's position; (2) the *Md. Dep't of Health and Mental Hygiene* case is not binding on DHS's interpretation of "not covered under the State Plan;" and (3) as the enforcing agency, deference should be given to DHS's interpretation of "not covered under the State Plan."

1. The Most *Recent* Court to Consider this Issue Declined to Follow *Md. Dep't of Health and Mental Hygiene*

As previously noted, the Petitioner's arguments are based primarily on *Md. Dep't of Health and Mental Hygiene.* However, the most recent court to deal with this issue declined to follow this decision. In *Goodwin v. Fla. Dep't of Children and Families,* 2016 WL 1295045 (2016), a nursing home patient challenged a denial of her request to deduct pre-eligibility nursing home costs. *Id.* at *1. When the Florida Department of Children and Families ("DCF") did not deduct her unpaid, pre-eligibility nursing home costs, she appealed to DCF's Office of Appeals and Hearings. *Id.* at *1-2. The hearing officer issued a final order, stating that 42 U.S.C. §1396a(r)(1)(A)(iii) did not require DCF to deduct all of her pre-eligibility nursing home costs. *Id.* at *2.

On appeal, the nursing home patient raised the same arguments raised in this appeal by the Petitioner and cited to *Md. Dep't of Health and Mental Hygiene* in support of her position. The court rejected her argument, noting that (a) the court had to defer to DCF's interpretation since DCF was the enforcing agency and (b) that no deference had to be given to the position taken by CMS in *Md. Dep't of Health and Mental Hygiene* since this was a mere litigation position. *Goodwin* at *4, citing *Heimmermann v. First Union Mortg. Corp.*, 305 F.3d 1257, 1262 (11th Cir. 2002) and *William Bros. v. Pate,* 833 F.2d 261, 265 (11th Cir. 1987).

In her brief, the Petitioner acknowledges *Goodwin* but argues that this decision is not persuasive "because of a mishap in civil procedure and lack of substantive argument." While it's true that the court in *Goodwin* mentioned that the *Md. Dep't of Health and Mental Hygiene* had not been raised below and that the nursing home patient did not explain why this decision was binding on DCF's calculation, this does not change the fact that the court still considered the arguments based on *Md. Dep't of Health and Mental Hygiene* and issued a finding that this decision was not persuasive and not binding on DCF. *Goodwin* at *4.

2. *Md. Dep't of Health and Mental Hygiene* Decision is not Binding on DHS's Interpretation of "Not Covered Under the State Plan"

As the court in *Goodwin* noted, "there is no basis [...] for equating CMS's litigation position in *Maryland* with an authority binding on DCF." *Goodwin* at *4. Similarly, there is no basis for this position to be binding on DHS in the case at hand. DHS was not a party to *Md. Dep't of Health and Mental Hygiene,* and CMS is not a party to this action.

Although the Petitioner cites to *Chevron* in her brief in support of her position that CMS's interpretation of 42 U.S.C. §1396a(r)(1)(A)(iii) in *Md. Dep't of Health and Mental Hygiene* should be given deference, litigation positions "are the kinds of informal policy positions that lack the force of law and are unentitled to *Chevron* deference." *Heimmermann v. First Union Mortg. Corp.,* 305 F.3d 1257, 1262 (11th Cir. 2002).

The position taken by CMS in *Md. Dep't of Health and Mental Hygiene* is not binding on DHS's interpretation of "not covered under the State Plan."

3. Deference Should be Given to DHS's Interpretation

It is well established law in Arkansas that an agency's interpretation of its own rules is highly persuasive. *Northpoint v. Ark. Dep't of Human Servs.,* 2009 Ark. 619, 363 S.W.3d 308 (2009); *Sparks Reg'l Med. Ctr. V. Ark. Dep't of Human Servs.,* 290 Ark. 367, 719 S.W.2d 434 (1986). Courts ordinarily uphold an agency's interpretation of its own rule unless it is clearly wrong. *Northpoint v. Ark. Dep't of Human Servs.,* 2009 Ark. 619, 363 S.W.3d 308 (2009); see also Ark. *Savings and Loan Assoc. Bd. v. Grand Prairie Savings and Loan Assoc.,* 261 Ark. 247, 547 S.W.2d 109 (1977) (an administrative agency's interpretation of its own rule is controlling unless plainly erroneous and inconsistent); *Baker v. Heckler,* 730 F.2d 1147 (8th Cir. 1984) ("[w]e must accept the agency's interpretation, if it is reasonable in terms of the words of the regulation and purposes of the statute, even though, as an original matter, we might have reached a different conclusion").

In her brief, the Petitioner repeatedly refers to CMS as the "Agency" whose interpretation is owed deference. However, as the court in *Goodwin* acknowledged, in situations such as the one at hand, it is DHS's interpretation which must be given deference since DHS is the enforcing agency. *Goodwin* at *4. As previously stated, DHS has consistently interpreted MS § H-410 as not allowing for nursing

home costs incurred prior to an individual's eligibility to be subject to income offset.

Considering any potential ambiguities in the pertinent language of 42 U.S.C. § 1396a(r)(1)(A)(ii) and the fact that there is no clear precedent as to how to interpret this language, the court should defer to DHS's interpretation of its own State Plan.

Conclusion

For the above-stated reasons, DHS asks that the Petitioner's appeal be dismissed and that the previous decision to deny her request to deduct pre-eligibility nursing home costs be upheld.

Respectfully submitted,

Arkansas Department of Human Services
Office of Chief Counsel

By:/s/ Nick R. Windle

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Certificate of Service

I, undersigned, do hereby certify that on this 5th day of August, 2016, a true and correct copy of the foregoing pleading was sent to the following individual via e-mail:

Collier Moore
Attorney for Petitioner

/s/ Nick Windle
Nick Windle

APPENDIX J

BEFORE THE DEPARTMENT OF HUMAN SERVICES OF THE STATE OF ARKANSAS

IN THE MATTER OF:

VELMA MARTINDALE PETITIONER

VS. CASE NO. 20163249

DIVISION OF AGING AND ADULT SERVICES RESPONDENT

FINAL ORDER

INTRODUCTION

The Division of Aging and Adult Services denied Velma Martindale's request for an offset of her income which is attributed to her liability to the nursing facility in which she resides. She requested the offset in order to pay for services rendered at time which she was ineligible for Long Term Care Medicaid.

The parties agreed to waive an administrative hearing and submit briefs in lieu of a hearing. From all things and matters of record, the following Findings of Fact, Conclusions of Law, and Decision are entered.

FINDINGS OF FACT

1. Velma Martindale requested a post-eligibility income offset to cover $15,046.48 in long term

care facility expenses she incurred during a period of time she was ineligible for Long Term Care Medicaid.

2. Ms. Martindale's income offset was denied by the Division of Aging and Adult Services because long term care facility expenses are covered in the state plan and an income offset can only be granted for services not covered in the state plan.

3. Based on the evidence submitted I find that the Division of Aging and Adult Services correctly denied Ms. Martindale's request for an income offset.

CONCLUSIONS OF LAW

Applicants for Medicaid payment for nursing home facility services must establish eligibility for the payments. Medical Services Policy (MSP) B-331. "[T]he burden is on the applicant to prove her eligibility to the satisfaction of the administrative agency." *Williams v. Scott*, 278 Ark. 453,647 S. W. 2d 115 (1983). Arkansas DHS Administrative Procedures: Appeals and Hearings Procedures § 1098.2.4 states, in the pertinent part, that an appellant seeking to establish eligibility for DHS benefits or services has the burden of proving his or her eligibility.

A Medicaid beneficiary is responsible for charges incurred during a time of ineligibility. Arkansas Medicaid Manual § 132.000. Non-covered services are services not covered under the Medicaid program Arkansas Medicaid Manual § IV — Glossary. Medical Services Policy H-410 is

consistent with the authority provided in the Arkansas State Medicaid Plan. The State Medicaid Plan provides for an income offset for medical expenses not covered under the Plan.

The Arkansas Medicaid plan covers long term care facilities payments. The Arkansas Medicaid Plan for long term care facility reimbursements is stated in the Medical Assistance Program Manual of Cost Reimbursement Rules for Long Term Care Facilities. Consequently, long term care facility cost incurred prior to an individual's eligibility is not subject to an income offset. The Division of Aging and Adult Services correctly denied Ms. Martindale's request for an income offset.

DECISION

Velma Martindale failed to meet her burden of proof that he is eligible for a post-eligibility income offset to cover her long term care facility expenses incurred during a period of time she was ineligible for Long Term Care Medicaid.

The decision to deny her request is hereby upheld.

/s/ Wayne Davis
Wayne Davis, Hearing Officer
Office of Appeals and Hearings

September 16, 2016
Date

APPENDIX K

H-2150 Non-Allowable Deductions – General IME

Revision 16-2; Effective June 1, 2016

Texas Health and Human Services Commission (HHSC) does not allow deductions for:

- items covered by the nursing facility (NF) vendor payment (including, but not limited to, diapers, sitters, durable medical equipment, dietary supplements or physical, speech, or occupational therapy);
- covered services that are beyond the amount, duration, and scope of the Medicaid state plan (including, but not limited to, additional prescription drugs);
- services covered by the Medicaid state plan but delivered by non-Medicaid providers;
- expenses for medical services received before the applicant's medical effective date;
- premiums for cancer or other disease-specific insurance policies, or general health, dental, or vision insurance policies with benefits that cannot be assigned;
- premiums for insurance policies that pay a flat rate benefit to the insured or income maintenance policies;
- health care services provided outside of the U.S.;

- expenses incurred during a transfer of assets penalty (including, but not limited to, nursing facility bills);
- expenses for eyeglasses, contact lenses, hearing aids, services provided by a chiropractor or a podiatrist (these are covered through the Medicaid program);
- expenses covered by STAR+PLUS managed care organizations (MCOs) either:
    - as an NF add-on service, including medically necessary durable medical equipment, such as customized power wheelchairs (CPWCs), augmentative communication devices (ACDs), emergency dental services, and physician ordered rehabilitation services (also called goal directed therapies); or
    - as value-added services (VAS). VAS are extra benefits offered by an MCO beyond Medicaid-covered services. VAS may include routine dental, vision, podiatry, and health and wellness services. **Note**: A recipient may choose to utilize the MCO VAS or the IME process; and
- expenses incurred by Medicaid-eligible recipients 21 years of age or older requiring mental health and counseling services provided by a licensed psychologist, licensed professional counselor, licensed clinical social worker or a licensed marriage and family therapist (effective for dates of service on or after Dec. 1, 2005).