UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
SOUTHERN DIVISION

KERRY GROWDON, by Robert T. Foister & Gregory D. Willett, Conservators	)	
Plaintiff,	)	CASE NO. _____
v.	)	
PATTI KILLINGSWORTH, ASSISTANT COMMISSIONER & CHIEF OF LONG TERM CARE, BUREAU OF TENNCARE; DARIN GORDON, DIRECTOR, BUREAU OF TENNCARE; MARK EMKES, COMMISSIONER, TENNESSEE DEPARTMENT OF FINANCE & ADMINISTRATION; and RAQUEL HATTER, COMMISSIONER, TENNESSEE DEPARTMENT OF HUMAN SERVICES	)	
Defendants.	)	

COMPLAINT

INTRODUCTION

1. The defendants are violating Plaintiff Kerry Growdon's rights under the Medicaid Act.[1] As a nursing-home resident receiving TennCare (Tennessee's Medicaid program), Ms. Growdon must use her available monthly income toward the cost of her care (patient liability). The Act allows for a reduction of Ms. Growdon's countable monthly income and a corresponding reduction in the amount of her patient liability to enable her the ability to pay certain necessary medical expenses not covered by TennCare. This policy allows nursing-home residents like Ms. Growdon to retain enough income to pay off their non-covered medical expenses while ensuring

[1] 42 U.S.C. §§ 1396a *et seq*. (the "Medicaid Act" or "Act").

that the costs of their nursing-home stay is covered. Despite clear federal guidelines and the provisions of the TennCare plan, TennCare is refusing to reduce Ms. Growdon's countable monthly income by her non-covered medical expenses with a corresponding reduction to her patient liability. Ms. Growdon is entitled to a declaration that TennCare's policy violates federal law, an injunction requiring TennCare to reduce her countable income allowing her to use her income to pay off her non-covered medical expenses, and other relief.

JURISDICTION & VENUE

2. This Court has jurisdiction of this action under 28 U.S.C. § 1331.

3. This Court is a proper venue for this action under 28 U.S.C. § 1391(b).

PARTIES

4. Plaintiff Kerry Growdon is 62 years old. Ms. Growdon is a disabled person under Tennessee law and is the subject of a conservatorship (Chancery Court for Hamilton County, Tennessee, Part 1, Case No. G-0518). Ms. Growdon lives in the nursing facility section of Orange Grove Center in Chattanooga, Tennessee. Orange Grove is a private, non-profit organization serving adults and children with developmental disabilities. Ms. Growdon has lived in the nursing facility section of Orange Grove since July 2010. Ms. Growdon's conservators, Robert T. Foister and Gregory D. Willett, bring this action on her behalf. (*See* Letters of Conservatorship, attached as **Exhibit A**.)

5. Defendant Patti Killingsworth is an Assistant Commissioner of the Bureau of TennCare and its Chief of Long Term Care. The Tennessee Department of Finance and Administration is the state agency charged with administering the TennCare program. The Bureau of TennCare is the part of the Department of Finance and Administration that administers and sets policy for TennCare.

6. Defendant Darin Gordon is the Deputy Commissioner of the Tennessee Department of Finance and Administration and the Director of the Bureau of TennCare.

7. Defendant Mark Emkes is the Commissioner of the Tennessee Department of Finance and Administration.

8. Defendant Raquel Hatter is the Commissioner of the Tennessee Department of Human Services (DHS). DHS determines a person's eligibility for TennCare according to policies established by the Bureau of TennCare. DHS also conducts administrative hearings and appeals and makes the final administrative decisions in cases in which persons claim to be aggrieved by DHS's TennCare-eligibility decisions.

FACTS

9. The Medicaid Act prescribes a two-step process for determining Medicaid eligibility and benefits for a nursing-home resident. In the first stage, eligibility is determined by computing the person's gross income and comparing that to the Medicaid income eligibility level. If the gross income is less than the Medicaid income eligibility level the person is deemed eligible for Medicaid. In Tennessee, if an individual is over the income eligibility level, a Qualified Income Trust (also known as a QIT or Miller Trust) can be used pursuant to 42 U.S.C. § 1396p(d)(4)(B) for the individual to qualify for Medicaid benefits. Once the individual is determined to be eligible for Medicaid benefits from an income prospective, a patient liability is computed in the second stage, the "post-eligibility" stage. Ms. Growdon established a QIT and was determined to be income eligible for Medicaid benefits starting in September of 2010.

10. In the second stage, the nursing-home resident's gross income is required to be reduced by certain deductions to determine the amount of the patient liability. Among the required deductions are necessary medical or remedial care expenses recognized under state law but not subject to payment by the state's Medicaid plan or any other third party. 42 U.S.C. §

1396a(r)(1)(A)(ii); 42 C.F.R. § 435.725. After appropriate deductions, the balance of the nursing-home resident's gross income is the amount of the patient liability.

11. In July 2010, Ms. Growdon entered the nursing facility section of Orange Grove, where she still resides. Ms. Growdon, however, did not become eligible for TennCare until September 2010. DHS determined that the effective date of Ms. Growdon's TennCare coverage was September 1, 2010; thus, her nursing home care from September 1, 2010, forward has been or is to be paid for by TennCare.

12. Ms. Growdon, however, incurred and continues to owe Orange Grove for nursing home care she received in July and August, 2010, months in which she was not eligible for TennCare. These expenses total $21,723.66. Orange Grove has not written off or forgiven these expenses. Ms. Growdon is and remains solely responsible for paying these expenses. These expenses, known as pre-eligibility medical expenses or PEMEs, are necessary medical care expenses recognized under state law but not subject to payment by TennCare or any other third party (which TennCare refers to as "non-covered expenses"). This action concerns whether, as part of the patient-liability computation, TennCare must deduct Ms. Growdon's PEMEs.

13. The Medicaid Act allows states to establish "reasonable limits" on the amount of non-covered expenses such as PEMEs that nursing-home residents may deduct to reduce their patient liability. States must submit any proposed "reasonable limits" to CMS for approval as part of their Medicaid plans. In 2005 the State of Tennessee submitted a proposed amendment to its State Medicaid Plan to CMS for approval (copy attached as **Exhibit B**). The proposed amendment dealt with non-covered medical expense deductions from income but did not allow for the deduction of PEMEs. The proposed amendment was not approved as submitted; the

amendment that was approved by CMS in 2005 expressly allowed for PEMEs to be deducted from eligible individuals' monthly income (copy attached as **Exhibit C**).

14. Under a March 1, 2011, state plan amendment (SPA), Tennessee established a limit on the amount that nursing-home residents may deduct for non-covered expenses such as PEMEs. The operative SPA limited the non-covered medical expenses that could be deducted from income by nursing-home residents to only those expenses which were incurred within three months of the month in which they applied for TennCare. Thus, PEMEs "incurred more than three months prior to the month of application for [TennCare] are disallowed as a deduction from patient liability." (Supplement 3 to Attachment 2.6-A, "Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid," effective March 1, 2011, copy attached as **Exhibit D**).

15. TennCare refers to non-covered expenses that may be deducted as "Item D Expenses."

16. On September 9, 2011, Patti Killingsworth, an Assistant Commissioner of the Bureau of TennCare and its Chief of Long Term Care, issued a memorandum to Medicaid nursing facility administrators and others (Killingsworth Memo, copy attached as **Exhibit E**). The Killingsworth Memo purports to explain changes that the March 1, 2011, SPA made to TennCare regarding "allowable medical deductions from patient liability (commonly referred to as 'Item D')." (*Id*.) The Killingsworth Memo recognized that, under the SPA, "allowable medical expenses incurred within three months prior to the month of application for Medicaid are allowed as an item D expense." (*Id*.) However, the Killingsworth Memo went further, stating that allowable medical expenses incurred within three months prior to the month of application for Medicaid may be deducted to reduce patient liability only if "the person would

have been income and resource eligible [*i.e.*, eligible for Medicaid] at the time the expense was incurred." (*Id.*)

17. The "eligibility" requirement stated in the Killingsworth Memo is directly contrary to the Medicaid Act, the TennCare plan and the TennCare Policy Manual. In fact, the TennCare Policy Manual states, "Medical expenses incurred during Medicaid/TennCare ineligibility **do not impact** on whether the bill is an allowable medical expense." (TennCare Policy Manual (Dec. 2009), at p. 142, excerpts attached as **Exhibit F**) (emphasis added). The TennCare Policy Manual then offers this example:

> Mrs. Carter applied for Medicaid/TennCare for the month of January. She did not meet Medicaid/TennCare eligibility for that month. She reapplied for March. The expense applied in the previous month, but which did not result in eligibility, may be used as an Item D in a later month if still owed and there are plans to pay the expense.

(*Id.*)

18. After becoming eligible for TennCare, Ms. Growdon twice requested that her PEMEs be deducted from her income to reduce her patient liability. DHS ignored her requests.

19. Ms. Growdon raised the issue by appealing the amount of her patient liability through DHS's administrative appeals process. At each level, DHS has denied Ms. Growdon relief.

20. On March 19, 2013, DHS entered its final order denying Ms. Growdon's request for relief. (Final Order, by Michelle Waldrop, Assistant Commissioner, Appeals & Hearings, entered March 19, 2013, copy attached as **Exhibit G**.) In that order, DHS explicitly relied on the Killingsworth Memo to hold that Ms. Growdon cannot use her PEMEs to reduce her patient liability. As the order states,

> Clearly, the Memo from Ms. Killingsworth establishes TennCare policy regarding "Item D" expenses incurred within three (3)

> months prior to the month of application for Medicaid. Pursuant to the Memo the [applicant] would have to have been income and resource eligible at time the "Item D" expense was incurred. Pursuant to Tenn. Comp. R. & Regs. 1200-13-13-.02(b)&(c), the Department of Human Services must determine eligibility for Medicaid according to policies established by TennCare. Additionally, a Department of Human Services Hearing Official has no authority to rule on the validity of a TennCare policy. *See Tenn. Comp. R. Regs. 1240-5—5-.01(1)*. There is no factual dispute that the Appellant [Ms. Growdon] was not income or resource eligible prior to September 1, 2010. As such the Hearing Officer properly dismissed this portion of the appeal under *Tenn. Comp. 1240-5-3-.04(3) & (6)*.

(*Id*.)

STATEMENT OF CLAIM

21. The defendants are violating Ms. Growdon's rights under 42 U.S.C. § 1396a(r)(1) and 42 C.F.R. § 435.725 by refusing to deduct her PEMEs in computing her post-eligibility income and corresponding patient liability, for which relief is available pursuant to 42 U.S.C. § 1983 and the Supremacy Clause of the Constitution of the United States.

22. The defendants are violating 42 U.S.C. § 1396a(r)(1) and 42 C.F.R. § 435.725 by applying the "eligibility" requirement stated in the Killingsworth Memo. As DHS's Final Order states, the "eligibility" requirement is the policy of the Bureau of TennCare. (**Exhibit G**, at p. 3.) That policy has materially and adversely affected Ms. Growdon's right to use her monthly income to pay her past due and unpaid medical expenses that were incurred within the three months prior to her becoming eligible for TennCare benefits.

23. Tennessee did not include the "eligibility" requirement stated in the Killingsworth Memo in the proposed plan amendment submitted to CMS for approval. In fact, CMS rejected Michigan's attempt to impose the same requirement, stating "[n]ursing home costs incurred prior to a period of Medicaid eligibility are deductible under the post eligibility process, since these expenses were incurred when the person was ineligible for Medicaid and thus Medicaid did not

pay for them." *Miller ex rel. Morrish v. Olszewski*, No. 09-13683, 2009 WL 5201792, at *5 (E.D. Mich. Dec. 21, 2009) (quoting letter of September 28, 2005, from Gale P. Arden, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, CMS).

WHEREFORE, Ms. Growdon demands judgment:

1. Entering a declaration and a permanent injunction requiring the defendants, their subordinates, agents, and assigns to deduct Ms. Growdon's PEMEs, incurred in July and August 2010, from her post-eligibility income and adjust her patient liability accordingly.

2. Ordering the defendants to cause the Bureau of TennCare and DHS to change their policy immediately to comport with 42 U.S.C. § 1396a(r)(1) and 42 C.F.R. § 435.725 and to publish such changes to all state offices and agencies administering TennCare policy.

3. Awarding Ms. Growdon reasonable attorney's fees and costs pursuant to 42 U.S.C. § 1988 and all other relief to which she is entitled.

CHAMBLISS, BAHNER & STOPHEL, P.C.

By: */s/ D. Aaron Love*
Stephen D. Barham (BPR No. 019292)
D. Aaron Love (BPR No. 026444)
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rml@ronmlandsman.com

Attorneys for Plaintiff Kerry Growdon

JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS
KERRY GROWDON, by Robert T. Foister & Gregory D. Willett, Conservators

(b) County of Residence of First Listed Plaintiff Hamilton
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)
Stephen D. Barham, Esq. and D. Aaron Love, Esq.
CHAMBLISS, BAHNER & STOPHEL, P.C.
Liberty Tower, Suite 1700, 605 Chestnut Street, Chattanooga, TN 37450

DEFENDANTS
PATTI KILLINGSWORTH, ASSISTANT COMMISSIONER & CHIEF OF LONG TERM CARE, BUREAU OF TENNCARE et al.

County of Residence of First Listed Defendant Davidson
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated or Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated and Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 151 Medicare Act ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans) ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholders' Suits ☐ 190 Other Contract ☐ 195 Contract Product Liability ☐ 196 Franchise	PERSONAL INJURY ☐ 310 Airplane ☐ 315 Airplane Product Liability ☐ 320 Assault, Libel & Slander ☐ 330 Federal Employers' Liability ☐ 340 Marine ☐ 345 Marine Product Liability ☐ 350 Motor Vehicle ☐ 355 Motor Vehicle Product Liability ☐ 360 Other Personal Injury ☐ 362 Personal Injury - Medical Malpractice PERSONAL INJURY ☐ 365 Personal Injury - Product Liability ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability ☐ 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY ☐ 370 Other Fraud ☐ 371 Truth in Lending ☐ 380 Other Personal Property Damage ☐ 385 Property Damage Product Liability	☐ 625 Drug Related Seizure of Property 21 USC 881 ☐ 690 Other	☐ 422 Appeal 28 USC 158 ☐ 423 Withdrawal 28 USC 157 PROPERTY RIGHTS ☐ 820 Copyrights ☐ 830 Patent ☐ 840 Trademark SOCIAL SECURITY ☐ 861 HIA (1395ff) ☐ 862 Black Lung (923) ☐ 863 DIWC/DIWW (405(g)) ☐ 864 SSID Title XVI ☐ 865 RSI (405(g))	☐ 375 False Claims Act ☐ 400 State Reapportionment ☐ 410 Antitrust ☐ 430 Banks and Banking ☐ 450 Commerce ☐ 460 Deportation ☐ 470 Racketeer Influenced and Corrupt Organizations ☐ 480 Consumer Credit ☐ 490 Cable/Sat TV ☐ 850 Securities/Commodities/ Exchange ☐ 890 Other Statutory Actions ☐ 891 Agricultural Acts ☐ 893 Environmental Matters ☐ 895 Freedom of Information Act ☐ 896 Arbitration ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision ☐ 950 Constitutionality of State Statutes
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	LABOR	FEDERAL TAX SUITS
☐ 210 Land Condemnation ☐ 220 Foreclosure ☐ 230 Rent Lease & Ejectment ☐ 240 Torts to Land ☐ 245 Tort Product Liability ☐ 290 All Other Real Property	☒ 440 Other Civil Rights ☐ 441 Voting ☐ 442 Employment ☐ 443 Housing/ Accommodations ☐ 445 Amer. w/Disabilities - Employment ☐ 446 Amer. w/Disabilities - Other ☐ 448 Education	Habeas Corpus: ☐ 463 Alien Detainee ☐ 510 Motions to Vacate Sentence ☐ 530 General ☐ 535 Death Penalty Other: ☐ 540 Mandamus & Other ☐ 550 Civil Rights ☐ 555 Prison Condition ☐ 560 Civil Detainee - Conditions of Confinement	☐ 710 Fair Labor Standards Act ☐ 720 Labor/Management Relations ☐ 740 Railway Labor Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Employee Retirement Income Security Act IMMIGRATION ☐ 462 Naturalization Application ☐ 465 Other Immigration Actions	☐ 870 Taxes (U.S. Plaintiff or Defendant) ☐ 871 IRS—Third Party 26 USC 7609

V. ORIGIN (Place an "X" in One Box Only)

- ☒ 1 Original Proceeding
- ☐ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from Another District (specify)
- ☐ 6 Multidistrict Litigation

VI. CAUSE OF ACTION
Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
42 U.S.C. § 1396a(a)(13) and 42 C.F.R. § 435.725; 42 U.S.C. §§ 1983, 1988
Brief description of cause:
Claim for violation of Plaintiff's rights under the Medicaid Act.

VII. REQUESTED IN COMPLAINT:
☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.
DEMAND $
CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY (See instructions)
JUDGE DOCKET NUMBER

DATE 5/17/13
SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY
RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

Chancery Court for Hamilton County, Tennessee

IN RE: KERRY GROWDON — Docket No. G-0518

S.S. No. 242-86-5810 — PART I

Letters of Conservatorship

Pursuant to T.C.A. § 34-1-129

To: **ROBERT T. FOISTER and GREGORY D. WILLETT,** Conservator

Whereas, it appearing to this Court that KERRY GROWDON (hereinafter *The Ward*) has been declared disabled, and the Court being satisfied to your rights to the Conservatorship of *The Ward*, and you having **given bond and** qualified according to law, and the Court having ordered that Letters of Conservatorship be issued to you; it is therefore

Ordered that you take into your possession, for the use and benefit of *The Ward*, the profits of the lands, tenements and hereditaments belonging to *The Ward* and also the goods, chattels and other personal estate of *The Ward*; to make all necessary decisions relating to the medical and personal needs of *The Ward*; to bring such suit or action in relation thereto as may be deemed necessary; to file with the Court within 60 days an Inventory, on oath, of all the estate which shall have come into your hands or possession; to exhibit annually an account of the income and disbursements thereof; and to renew your bond as such; and to faithfully perform all duties required of you by law in relation to this Conservatorship, and upon the conclusion of this Conservatorship, to make final settlement thereof; to deliver and pay to the person lawfully authorized to receive the same, the residue of said estate, including the profits arising therefrom. HEREIN FAIL NOT.

In witness whereof, I have issued these Letters on this 9th day of September, 2008.

S. LEE AKERS, CLERK & MASTER

By: Susan K. Smith
DEPUTY GUARDIAN CLERK

STATE OF TENNESSEE
COUNTY OF HAMILTON

I do solemnly swear that I will honestly and faithfully discharge the duties imposed on me by the Court as Conservator, including the timely filing of each inventory, accounting and any other statements as required by law for the benefit of *The Ward* and to spend and manage the assets of *The Ward* only as approved by the Court.

Robert T. Foister — RD Willett

Sworn to and subscribed before me this 9th day of September, 2008.

S. LEE AKERS, CLERK & MASTER

By: Susan K. Smith
DEPUTY GUARDIAN CLERK

Certificate

I, Clerk of this court, certify: i) this is a Court of Record; ii) the above is a true, full, and correct copy of the Letters of Conservatorship issued by this Court in this matter; and iii) these letters are still in full force and effect as of this date.

Witness my hand and seal this 9th day of September, 2008.

S. LEE AKERS, CLERK & MASTER

By: Susan K. Smith
DEPUTY GUARDIAN CLERK
HAMILTON COUNTY COURTHOUSE
CHATTANOOGA, TN 37402

Subscribed and sworn before me, this 10th day of September, 2008, a Notary Public in and for Oakland County, Michigan.

(Signature)

TABITHA MINOR
NOTARY PUBLIC, STATE OF MI
COUNTY OF MACOMB
My Commission expires 01/09, 2012

Exhibit A

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

June 23, 2005

Renard L. Murray
Associate Regional Administrator
Division of Medicaid
Centers for Medicare and Medicaid Services (CMS)
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 05-007 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This plan amendment is being submitted to point out deductions that may be made from total income available for the cost of long-term nursing home care.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. W. Hickey
Deputy Commissioner

D1055167

Exhibit B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Methodology Used for Deduction of Incurred Expenses for Necessary Medical or Remedial Care for Institutionalized Persons in the Post-Eligibility Application of Income.

The following deductions may be made from the total income available for the cost of long-term nursing home care in the following order:

1. Personal needs allowance: $40 for an individual.

2. Allocation to eligible dependent(s) at home reduced by the amount of the dependent's own income.

3. Monthly costs for health insurance premium(s) paid by the eligible individual.

4. Payments for ONLY the following types of medical or remedial care recognized under state law, but not encompassed within the State's Medicaid Plan, subject to the following criteria. (Types of medical or remedial care not included in this list are not allowable deductions.)

   a. Eyeglasses and necessary related services. Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges, or the Medicaid fee schedule.

      (i) Examination and refraction
      (ii) Frame
      (iii) Lenses (bifocal)
      (iv) Lenses (single)

   b. Hearing aids and necessary related services. Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges, or the Medicaid fee schedule.

      (i) Audiogram
      (ii) Ear mold
      (iii) Hearing aid
      (iv) Batteries

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

(v) Hearing aid orientation

c. Dental services. Deductions can be made for routine and emergency dental services and in accordance with the Bureau of TennCare's dental fee listing, whether such services are provided at a dental office, on-site at the long term care facility, or through a mobile dental services provider that contracts with the long-term care facility.

d. Specialized chairs such as electric wheelchairs. Deductions will be restricted to the lesser of the Medicare prevailing charges or the Medicaid fee schedule.

5. Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days when the recipient is away from the nursing facility are not allowable deductions. These charges are allowed when the individual is in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

6. Charges incurred by the resident as a result of the nursing facility's failure to timely submit or renew a previously submitted Pre-Admission Evaluation (PAE) are not allowable deductions.

D1055167

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

November 15, 2005

J. D. Hickey, M.D., Deputy Commissioner
Department of Finance and Administration
Bureau of TennCare
729 Church Street
Nashville, TN 37247-6501

Attention: George Woods

RE: Tennessee Title XIX State Plan Amendment, Transmittal #05-007

Dear Dr. Hickey:

We have reviewed the proposed amendment to the Tennessee Medicaid State Plan that was submitted under transmittal number 05-007. This amendment proposes to place reasonable limits on the amount of incurred necessary medical and remedial care expenses which must be deducted from a nursing facility resident's income under the post eligibility treatment of income process.

Based on the information that has been provided, we are pleased to inform you that Medicaid State Plan Amendment 05-007 was approved on November 14, 2005. The effective date of this amendment is August 1, 2005. We are enclosing the approved HCFA-179 and plan pages.

If you have any questions or need any further assistance, please contact Cheryl Brimage at (404) 562-7116.

Sincerely,

Renard L. Murray

Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosures

Exhibit C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Methodology Used for Deduction of Incurred Expenses for Necessary Medical or Remedial Care for Institutionalized Persons in the Post-Eligibility Application of Income.

The following deductions may be made from the total income available for the cost of long-term nursing home care:

Payments for the following types of medical or remedial care recognized under state law, but not encompassed within the State's Medicaid Plan, subject to the following criteria.

1. Eyeglasses and necessary related services. Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges, or the Medicaid fee schedule.

   (i) Examination and refraction
   (ii) Frame
   (iii) Lenses (bifocal)
   (iv) Lenses (single)

2. Hearing aids and necessary related services. Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges, or the Medicaid fee schedule.

   (i) Audiogram
   (ii) Ear mold
   (iii) Hearing aid
   (iv) Batteries
   (v) Hearing aid orientation

3. Dental services. Deductions can be made for routine and emergency dental services and in accordance with the Bureau of TennCare's dental fee listing, whether such services are provided at a dental office, on-site at the long term care facility, or through a mobile dental services provider that contracts with the long-term care facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

4. Specialized chairs such as electric wheelchairs. Deductions will be restricted to the lesser of the Medicare prevailing charges or the Medicaid fee schedule.

5. Deductions for any other medical service recognized under State law but not covered by Medicaid will be made at the least of the provider's usual and customary charges, billed charges, or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the state to be medically necessary for the particular individual on whose behalf the services are being requested.

Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days that are in excess of the number of days covered under the Medicaid State Plan for the type of facility in question are not allowable deductions.

Revision: HCFA-PM-85-3 (BERC)

SUPPLEMENT 3 TO ATTACHMENT 2.6-A
Page 1
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Methodology Used for Deduction of Incurred Expenses for Necessary Medical or Remedial Care for Institutionalized Persons in the Post-Eligibility Application of Income.

The following deductions will be made from the total income available for the cost of long-term nursing home care:

Payments for the following types of medical or remedial care recognized under state law, but not encompassed within the State's Medicaid Plan or the TennCare Demonstration, subject to the following criteria.

1. Eyeglasses and necessary related services not covered under the State plan or the TennCare demonstration. Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges, or the Medicaid fee schedule.

   (i) Examination and refraction
   (ii) Frame
   (iii) Lenses (bifocal)
   (iv) Lenses (single)

2. Hearing aids and necessary related services. Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges, or the Medicaid fee schedule.

   (i) Audiogram
   (ii) Ear mold
   (iii) Hearing aid
   (iv) Batteries
   (v) Hearing aid orientation

3. Dental services. Deductions can be made for routine and emergency dental services and in accordance with the Bureau of TennCare's dental fee listing, whether such services are provided at a dental office, on-site at the long term care facility, or through a mobile dental services provider that contracts with the long-term care facility.

Exhibit D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

4. Deductions for any other medical service recognized under State law but not covered by Medicaid will be made at the least of the provider's usual and customary charges, billed charges, or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the state to be medically necessary for the particular individual on whose behalf the services are being requested.

Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days that are in excess of the number of days covered under the Medicaid State Plan for the type of facility in question are not allowable deductions.

Medical expenses incurred more than three months prior to the month of application for Medicaid are disallowed as a deduction from patient liability. Allowable medical expenses incurred within three months prior to the month of application will be allowed as a deduction from patient liability. No deduction will be allowed for medical expenses that were incurred as the result of imposition of a transfer of assets penalty period.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

IMPORTANT MEMO

DATE: September 9, 2011

TO: Administrators and Office Managers of Medicaid Nursing Facilities and ICFs/MR
CEOs and COOs of TennCare Managed Care Organizations

FROM: Patti Killingsworth, Chief of Long Term Care

SUBJECT: **IMPORTANT Information regarding Patient Liability and Item D Deductions**

This memo clarifies federal requirements pertaining to post-eligibility provisions (i.e., collection of patient liability), and advises you of recent changes made to the *Medicaid State Plan* regarding allowable medical deductions from patient liability (commonly referred to as "Item D").

I. **Clarification regarding Patient Liability**

As you know, **"patient liability"** is the **monthly** amount that persons receiving Medicaid-reimbursed LTC services are required to contribute to the cost of their care if their incomes are at certain levels. In the CHOICES program (as it was in the fee-for-service system prior to CHOICES), nursing facilities are obligated to collect each Medicaid resident's patient liability. Medicaid payments made by the MCO to the facility for each month must be reduced by the entire amount of patient liability due for that month.

Patient liability is applied only to the cost of long-term care services or hospice room and board charges, and cannot exceed total Medicaid payments for such services provided during the month.

In the CHOICES program, while an MCO may, for purposes of claims processing, convert a person's monthly patient liability to a daily (or per diem) amount, the MCO remains obligated to deduct the **entire monthly** patient liability amount from its payment for claims, so long as that amount does not exceed Medicaid payments for long-term care services or hospice room and board provided during that month. This means that if a person is absent from the facility and there is a non-covered day, (because the person has exhausted his bed hold days or the facility does not meet minimum occupancy requirements to bill bed hold days), the facility must still collect the patient liability amount for that day and the total Medicaid payments made by the MCO for the month must still be reduced by the total monthly patient liability amount, so long as the total patient liability collections do not exceed total Medicaid payments for nursing facility services or hospice room and board for the month.

Exhibit E

This does not preclude the facility from requiring a payment from the resident to hold the bed. However, the patient liability collected from the resident cannot be retained by the facility for that purpose, as the full monthly amount of patient liability must, pursuant to federal law, be deducted from payments made by the MCO.

Any payments made by an MCO for nursing facility services or hospice room and board for which all required monthly patient liability amounts were not deducted and/or any patient liability amounts collected and retained by a facility that were not used to reduce the Medicaid payments for nursing facility or hospice services constitute an overpayment of Medicaid funds.

Pursuant to §6402 of the Affordable Care Act, **providers (including MCOs) have 60 days from discovery to return any overpayments and provide explanation of the reason for the overpayment in order to avoid additional liability under the State and Federal False Claims Acts.** Nursing facilities should make these payments to the MCOs for services delivered under the CHOICES program. Explanation of the reason for the overpayment should accompany the payment to the MCO and be copied to TennCare. A copy of the Bureau's policy is attached hereto. Because federal post-eligibility provisions (i.e., collection of patient liability) is a federal requirement which has always been in effect, recovery is not limited to any particular time period.

II. **Changes in Allowable Item D Expenses**

As you also know, Item D deductions are allowable deductions from a person's patient liability amount for certain medical or remedial care that is **recognized under State law but not covered by the *Medicaid State Plan***. By definition, these should be expenses that are not covered by TennCare.

In that regard, two clarifications have been made in the *State Plan* with respect to benefits covered under the TennCare program that should not be allowed as Item D expenses. These changes were effective **March 1, 2011.**

a. Language has been added to clarify that **Item D deductions for "Eyeglasses and necessary related services" are limited to those medically necessary items "not covered under the *State Plan* or the TennCare Demonstration."** Items covered under TennCare include "Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state)... One pair of cataract glasses or lenses is covered for adults following cataract surgery." As such, these services and are not allowable Item D expenses. Items and services not covered under TennCare for adults age 21 and older, including "[r]outine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses" continue to be allowed as Item D deductions.

b. **Item D deductions are no longer allowed for specialized wheelchairs.** This is because wheelchairs (including customized and/or power wheelchairs) are covered as medically necessary by TennCare. For persons who are dual eligible, Medicare is the primary payer source. Regardless, the resident should not be responsible for payment of medically necessary wheelchairs, such that an Item D deduction is not appropriate. The *State Plan* has never provided for wheelchair repairs to be reimbursed as an Item D deduction.

In addition, the recent *State Plan Amendment* clarifies the period of time for which medical expenses incurred prior to the *month of* application for Medicaid can be deducted from patient liability. Based on the *new SPA*, **only those allowable medical expenses incurred within three months prior to the month of application for Medicaid are allowed as an Item D expense when the person would have been income and resource eligible at the time the expense was incurred.** Medical expenses incurred more than three months prior to the month of application are disallowed and may **not** be submitted as an Item D expense. No deductions will be allowed for medical expenses that were incurred as the result of imposition of a transfer of assets penalty period.

Please note also that Item D deductions are **not** allowed for non-covered bed hold days.

If facilities have any questions about this memo, please contact your TennCare MCO or the Long-Term Care Division.

PUBLISHED BY

TENNCARE MEDICAID

AND

TENNCARE STANDARD

POLICY MANUAL

DECEMBER 2009

TENNESSEE DEPARTMENT OF
HUMAN SERVICES

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Exhibit F

ITEM D DEDUCTIONS FOR INSTITUTIONALIZED INDIVIDUALS

The law allows the deduction for expenses incurred by the eligible individual for medical or remedial care that are recognized by state law as medical and/or remedial care items but are not included in the State's Medicaid/TennCare plan. Tennessee calls these non-covered expenses Item D.

Cost items are those medical/remedial services and/or goods that must be provided by the nursing care providers. Cost items cannot be charged to patient or allowed as an Item D deduction.

Allowable Item D Expenses

The deduction of these expenses is subject to the following limitations:

- The expenses(s) must not be subject to payment by a third party which does not expect reimbursement, e.g., medical/health insurance, the individual's spouse or family or medical trust fund, Medicare, etc.
- The expense may be unpaid OR paid by the client during the month(s) of eligibility determination OR paid by a member of the client's family and reimbursement is expected by the family member.
- The expense must not have been allowed previously as a necessary item.
- The expense must be outstanding and considered collectible by the party who provided the medical service and one for which the client is legally liable.
- Medical expenses incurred during Medicaid/TennCare ineligibility do not impact on whether the bill is an allowable medical expense. EXAMPLE: Mrs. Carter applied for Medicaid/TennCare for the month of January. She did not meet Medicaid/TennCare eligibility for that month. She reapplied for March. The expense applied in the previous month, but which did not result in eligibility, may be used as an Item D in a later month if still owed and there are plans to pay the expense.

NOTE: Non-covered prescriptions in a nursing home or HCBS cannot be used as an Item D expense for those with Medicare Part D.

Prescriptions that are not covered by Medicare Part D are not allowed as an item D deduction. TennCare no longer offers prescription coverage to individuals who are dually eligible for both Medicare and Medicaid; this includes individuals who are dually eligible in a long-term-care or HCBS setting. The nursing home industry throughout Tennessee has been notified of this policy by the TennCare Bureau.

NOTE: Non-covered prescriptions in a nursing home or HCBS cannot be used as an Item D expense for those with Medicare Part D.

Setting up a Deduction Schedule

A deduction schedule may be used to allow for a medical expense in determining eligibility and for Item D deductions of institutionalized individuals.

Item D deductions are made by using expenses from a previous quarter to project Item D expenses for a subsequent quarter. "Quarter" for the purposes of this section need not be calendar quarters but may be any 3 consecutive months. Expenses for the three months prior to the processing month plus any unused expenses for any prior month(s) are computed and projected effective the month after the processing month for a three month period.

Example: expenses incurred in May, June and July are processed in August and made effective for September, October, and November.

Once an Item D projection has been made, the next redetermination is due the third month of the projected quarter. For example, using the above projected quarter of September, October, and November, the next redetermination is due in November (processing month) using expenses for August, September and October to project for December, January and February.

An "adjustment to actual" will be made for each quarter's Item D's after the initial Item D determination.

Expenses incurred at any time are allowable as Item D's when there is a repayment plan, or the client expresses an intent of paying on the expense during the quarter under consideration. To allow deduction of these expenses the caseworker must determine:

- The total amount the client owes the provider and the outstanding balance.
- The date(s) the service(s) was provided.
- The amount of each monthly payment.
- The dates the first and last payments are due.

Allow deductions as payments are made during the months which are budgeted during the processing month. Do not continue to allow deductions for payment of expenses if it is discovered that payment is not being made, regardless of the type of payment or the existence of a repayment plan. Installment payments will be subject to the "adjustment to actual" process; however, one-time payments are not, as indicated below.

NOTE: Payment can only be made from the patient liability amount, not from the person's trust account or personal needs allowance. If the patient liability is already zero, no Item D can be allowed.

One-time Payments

One-time payments are those payments for medical/remedial expenses of $100 or more that are incurred only once and which are not paid in installment payments. One-time payments are not subject to the adjustment to actual process. They include expenses such as, eyeglasses, hearing aids, or dentures. One-time expenses may be deducted all in one month and removed effective the following month or prorated over 3 months.

On the data base, these expenses are encoded medical expenses rather than the Item D screen, AEFMD. The caseworker must set an Expected Change to remove the deduction of a one-time expense on a timely basis.

Qualifying Expenses

Allow deductions for payment of the following types of medical expenses as Item D's:

- **Acupuncture Services**
- Doctors' Fees - Fees for physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, chiropodists, podiatrists, psychiatrists, psychologists, Christian Science practitioners and others for medical services are allowable deductions if incurred during periods of Medicaid/TennCare ineligibility.
- **Guide Dogs**- Guide dogs for the blind or deaf and the costs of their maintenance are allowable medical expenses.
- **Organ Transplant Expenses** - Expenses for donor or prospective donor for an organ transplant including surgical, hospital, laboratory charges and transportation expenses are deductible unless covered by Medicaid/TennCare during an eligible period.
- **Medical Care Charges in Tuition Fees** - Charges for medical care included in the tuition fee of a college or private school, or in the "file care" fee of a retirement home which is paid on a monthly basis, are allowable expenses provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.
- **Prosthetic Devices** - Artificial teeth, limbs, eyeglasses, hearing aids, and component parts, and crutches are qualifying expenses if not provided by the MCO during a period of eligibility. Costs of examinations and upkeep of devices are also allowable deductions subject to limitations established by the TennCare Bureau.
- **Special Education for the Handicapped** - Special school for mentally or physically handicapped individuals if for alleviation of handicap. Example: The costs of sending a blind child to school to learn Braille, or a deaf child to lip

- reading classes, are medical expenses. The costs of meals and lodging, if supplied by the institution, and of ordinary education furnished incidental to the special services are also medical expenses if these expenses are not provided through the MCO. MCO's on a case by case basis may provide tuition at a private school, if it can be determined that this service is preventive in nature.

- **Special Equipment** - Special equipment, such as, a motorized wheelchair, one wheelchair ramp for the individual's place of residence, or an automobile especially equipped for use by a handicapped person are qualifying expenses.

- **Transportation** - Transportation essential to medical care, e.g., bus, taxi, train, or plane fare, and 42 cents for each mile that client's car is used for medical purposes, in addition to parking fees and tolls is an allowable medical expense.

- **Nursing Services** - Nursing services include nursing care in client's home if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder as prescribed by a physician. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as, the preparation of meals and the performance of housework is not deductible.

- **Psychiatric Care** - Psychiatric care primarily for alleviating a mental illness or defect and the costs of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care are allowable expenses if not incurred during Medicaid/TennCare ineligibility.

- **Hospital Charges (in Tennessee or another state)** - Qualifying expenses are hospital services, therapy and similar services, nursing services, (including nurses' board), laboratory, surgical, obstetrical, diagnostic services and x-ray fees not incurred during Medicaid/TennCare eligibility. Payment for sitters is not allowable, either in the hospital or the home.

- **Substance Abuse Treatment** - Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment is a qualifying expense if not incurred during Medicaid/TennCare eligibility.

- **Legend Drugs** – TennCare has reviewed the list of excluded categories of drugs under Medicare Part D and has determined that individuals who reside in a nursing facility and pay a portion of their cost of care may have the **medically necessary** prescription drugs listed below considered as an item D expense.

  - Medically necessary benzodiazepines
  - Medically necessary prescription cough and cold products
  - Medically necessary prescription vitamin and mineral products
  - Medically necessary smoking cessation products

- **Dental Services Provided in a LTCF** - There are certain requirements that must be met by the mobile dental service providers in order to have their services covered as an Item D deduction. Currently, in Tennessee, Magnolia Mobile Dental Services, Inc. is the sole mobile dental service provider.

  These are the requirements of the mobile dental service:

  - To obtain a signed consent form from the responsible party prior to performing any dental services. If the responsible party fails or refuses to sign the consent form and has not made any arrangements for alternative dental care, the long-term care facility is authorized to sign the form on behalf of the resident. The consent will remain valid for the length of the resident's stay (only one form per patient, not one per procedure), unless otherwise revoked by the responsible party.

  - To deliver the consent forms, along with the verification of services form, via hand delivery, mail or facsimile to the respective DHS office.

  - To contract with a dentist licensed in the State of Tennessee who is a Medicare/Medicaid provider. A licensed dentist must perform all services. The dentist's name and provider number must be entered on the Item D request form prior to submitting the bill to DHS.

  - To create and supply all new forms that are submitted from the mobile dental service provider and the long term care facility. The facility should ensure that a copy of these forms is kept on file in the patient records at the facility, along with proof that the services were provided by a licensed dentist.

  - These are the requirements for DHS:

    - Prior to authorizing any Item D expense received from Magnolia Mobile Dental Service, Inc., the caseworker must view and document in the data base that the consent form, the Item D request form, and the verifications of service form have been provided.

    - Any services related to the provision of dentures deemed medically necessary must be thoroughly documented in the electronic case record. Process the Item D request within thirty (30) days after receipt in the county office.

- Once the bills have been processed, the EC must notify the responsible party and the long term care facility of any action taken to approve (via data base notice and the appropriate data base screen) or deny (via the data base free form) the expenses as an Item D deduction. These expenses will be deducted from the patient's countable income. This will reduce the patient liability.

NOTE: Payment can only be made from the patient liability amount, not from the patient's trust account or the personal needs allowance. If the patient liability is already zero, then payment cannot be allowed.

Along with the changes in policies and procedures, new forms were created to aid in the processing of dental expenses once they have been submitted to DHS. The forms and their use are as follows:

- Consent for Dental Treatment - A copy of this form should be submitted to DHS via hand delivery, mail or facsimile to verify that the responsible party or the long-term care facility has given consent for a patient to have dental treatment. The original should be kept on file at the long-term care facility. The consent form will remain valid as long as the patient resides at the long-term care facility.

- Item D Request – This form should be submitted to DHS via hand delivery, mail or facsimile, reporting that a particular service has been provided and the cost of those services. This form should be completed with the name of the dentist and his/her licensing number.

- Verification of Services – This form should be completed and signed by a long-term care facility representative verifying that the service identified on the Item D request has been completed. This form should be submitted simultaneously with the Item D request form.

- Denture Medical Necessity Form – This form should be completed and signed by the Attending Physician or the Medical Director of the facility to proceed with providing dentures.

NOTE: The above forms will be created and supplied to the long term care facility nursing home by Magnolia Mobile Dental Services Inc. However, DHS will maintain a copy of the Verification of Services Form in our GroupWise Default Library to provide to the long-term care facility upon request.

Non-Qualifying Expenses

The following incurred expenses are non-qualifying and cannot be deducted when determining patient liability.

- Expenses for LTC residents for items identified as SNF/IDV cost items in the State's Medicaid plan. At least 1 medication in each of 5 Non-Legend Therapeutic categories must be supplied by the LTCF: Analgesics, Antacids, Cough and Cold Remedies, Laxatives, and Miscellaneous.

- Expenses incurred prior to the individual becoming eligible for Medicaid/TennCare or in a prior period that meet any of the following conditions:

Charges that have been written off as uncollectible or have been forgiven by the provider. Expenses subject to payment (in full or in part) by third party resources (e.g. insurance, court-ordered medical support, etc.).

- Expenses that are not "medical" for purposes of this section.

Item D Adjustment to Actual

An adjustment to actual is the process of reconciling projected Item D's with Item D's actually incurred during the same months. The difference between the actual and projected expenses is then added to or subtracted from the actual and projected expenses over the next quarter. The adjustment to actual is never made if the individual is claiming an Item D deduction for the first time, or it has been more than a quarter since the last Item D was incurred.

An adjustment to actual is made only if there were projected Item Ds (not including one-time expenses) for any months of the previous quarter. NOTE: A projection of zero ($0) due to the adjustment to actual process in any month in the previous quarter is subject to an adjustment to actual if Item Ds were actually incurred.

Item D expenses used in the processing month to project expenses for a subsequent quarter will include:

- Expenses for the 3 months prior to the processing month, PLUS

- Any unused expenses from any past period which remain due, have not been previously used as expenses, and which will be paid on during the projected quarter.

Item D expenses do not include any one-time expenses of $100 or more for one-time purchase of glasses, hearing aids, dentures, etc., as these expenses will cause radical fluctuations in the adjustment to actual process.

During an initial Item D determination:

- Add countable expenses for the previous three months prior to the processing month;
- Divide by three and project the average monthly amount effective the month following the processing month;
- Schedule the next redetermination for the third month of the projected quarter.

EXAMPLE: Months 1, 2, 3 4 5, 6, 7

Expenses Incurred----------Processing Month----------Projected Months

Item D redeterminations for cases in which there was a projected expense for any month of the prior quarter must be adjusted to actual. To adjust to actual:

- Determine the actual expenses for the three months prior to the processing month
- Subtract the total projected expenses for the three months prior to the processing month from the total actual expense determined for those same months
- The + or – difference determined above is either added to or subtracted from the actual to determine the amount to be projected for a subsequent quarter.

EXAMPLE #1: Item D (Re)determinations:

Mr. A reports his first Item D expenses for May, June and July in August of $15, $10, and $25 respectively. This actual Item D determination is processed in August.

May	15
June	10
July	25
	50 divided by 3 = $16.67 month effective Sept., Oct., Nov.

At the redetermination in November (third month of projected quarter), the following expenses are reported for the previous three months:

Actual			Projected		
August	20.00		August	0	
September	10.00		September	16.67	
October	5.00		October	16.67	
	35.00	Actual		33.34	Projected
	- 33.34	Projected			
	1.66	Difference			

35.00 Actual
36.66 divided by 3 = 12.22 month effective Dec., Jan., and Feb.

EXAMPLE #2: Item D (Re)determinations

At the second redetermination in February, the following expenses are reported for the previous months:

Actual			Projected		
November	0		November	16.67	
December	5.00		December	12.22	
January	10.00		January	12.22	
	15.00	Actual		41.11	Projected
	41.11	Projected			
	26.11	Difference			
	+ 15.00	Actual			
	- 11.11	divided by 3 = $0 month effective March, April, and May			

EXAMPLE #3: Item D (Re)determinations

During the third redetermination in May, Mr. A. reports these expenses:

Actual			Projected		
February	5.00		February	12.22	
March	15.00		March	0	
April	0		April	0	
	20.00			12.22	
	- 12.22				
	7.78				
	20.00				
	27.78	divided by 3 = 9.2 month effective June, July, and August			

Item Ds which Exceed Income

When the projected Item D is greater than the individual's income, deduct only the amount equal to the available income. The Item D amount in excess of the income is considered a liability overcharge to be deducted at a future time when there is income to deduct it. Liability overcharges are not subject to the adjustment to actual process.

EXAMPLE:

Patient Liability Budget			Computations
Gross Income	$280	80	Actual Monthly Item D
Minus PNA	- 50	- 55	Budgeted Item D
Remainder	230	25	Monthly Excess Item D
Minus spousal/ Dep. Allocation	- 150	x 3	
Remainder	80	75	Quarterly Liability Overcharge to be budgeted when there is deduction of Item Ds in the "Patient Liability" budget.
Health insurance	- 45		
Remainder	35		
Minus Item D	55		
Patient Liability	0		

If Item Ds cannot be adjusted in future months due to death or discharge, see below.

Correction of Patient Liability Overcharge Errors

When a Patient Liability error occurs which results in a client overcharge,

- Complete a patient liability overcharge adjustment for a future month(s) if the client has enough income to adjust in the next month's patient liability OR
- Send in a "correction" 2362 for the month in question provided it is not for an adjustment more than 24 months prior to the processing month.

Document the electronic case record regarding the overcharge (how, when, why and how much) and how it is being adjusted. Adjust the overcharge the next effective month if the entire adjustment can be made in one month. If not, a 2362 with "correction" written at the top of the form should be completed for the month(s) the overcharge occurred.

Patient liability overcharges subject to an adjustment include agency errors and retroactive reduction in VA A&A to $0.

Item Ds for Month of Discharge/Death

In closing out vendor eligibility, the last month's patient liability must be redetermined to include Item Ds not preciously counted. Item Ds incurred for months not used in the latest Item D redetermination and those projected months occurring after the month of death/discharge are added to the projection for the month of death/discharge. The total is the amount to be deducted as an Item D in the month of death/discharge.

No adjustment to actual is made during this time as this is a final accounting of all unused Item Ds including those Item Ds for the month of discharge/death that could not be used previously because patient liability was zero (i.e., patient liability overcharges as illustrated above). Any additional Item Ds that cannot be offset by the client's income in

the last month of institutionalization may be processed as correction of a patient liability overcharge as indicated above.

EXAMPLE: Mrs. Maxell was discharged on October 3. She had Item Ds projected of $40 a month for October, November, and December (using expenses incurred in June, July, and August and processed in September). Expenses incurred in August of $15 and $20 in September which were not used plus the $40 each November and December are added to the $40 projected for October to determine the final Item D deduction.

$15	August unused Item D
20	September unused Item D
40	October projected Item D – not used
40	November projected Item D – not used
+ 40	December projected Item D – not used
155	Total Item D deduction for October

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
DIVISION OF APPEALS AND HEARINGS
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BILL HASLAM
GOVERNOR

RAQUEL HATTER, MSW, Ed.D.
COMMISSIONER

FINAL ORDER

Kerry M. Growdon, APPELLANT

Docket: MA 121002306
Case: 0004229631

VS

TENNESSEE DEPARTMENT OF HUMAN SERVICES

The Hearing Record and Petition for Reconsideration of the Final Order were reviewed on the 19th day of March, 2013, by the Assistant Commissioner, Division of Appeals and Hearings, who is the Hearing Authority for the Commissioner of the Department of Human Services ("the Department"). The issue of the appeal was originally the patient liability for the Appellant's long-term care in a facility. However, at hearing the parties agreed that the issue was whether the Department properly failed to consider certain medical expenses as Item D expenses.

In July 2010 the Appellant was admitted to the Orange Grove enter in Chattanooga, TN ad incurred medical expenses for twenty-three (23) days in July 2010 and all of August 2010. The Appellant filed a Medicaid application on August 6, 2010, however an interview was never completed and the application was denied. The Appellant filed a second application on September 14, 2010, which was approved after the Department verified that the Appellant created a valid Qualified Income Trust. After establishing a Qualified Income Trust, the Appellant became eligible for Medicaid beginning on September 1, 2010. On January 31, 2012 the Appellant first informed the Department of the Medicaid expenses incurred in July and August, 2010 and requested that they be treated as "Item D" expenses. On January 31, 2011 the Department sent a notice to the Appellant informing her that her patient liability would change on March 1, 2011. The Department sent the Appellant another notice on September 9, 2011 again adjusting her patient liability as of October 1, 2011. On October 1, 2012 the Department sent the Appellant notice that her patient liability would be increased from $2,298.00 to $2,325.00. On October 19, 2012 the Appellant timely filed this appeal and her patient liability was restored to $2,298.00 pending the outcome of this appeal.

An administrative hearing was conducted on the 3rd day of December, 2012, before Hearing Officer Ennica Street Elizabeth "Libby" Sponholtz, Esq. The Hearing Officer entered an Initial Order on January 16, 2013, concluding that the Department properly declined to use expenses incurred by the Appellant for

Exhibit G

twenty-three (23) days in the July 2010 and all of August 2010 as Item D expenses and dismissed this portion of the appeal. The Hearing Officer relied upon a Policy Memo from Patti Killingsworth at the Bureau of TennCare ("TennCare"), dated September 9, 2011, which clarified the TennCare's policy regarding Patient Liability. The Hearing Officer notes that according to the Memo, TennCare considered expenses incurred by an applicant for Medicaid as "Item D" expenses if incurred during the three (3) months prior to actual eligibility, but imposed a limit that an applicant must be income and resource eligible for Medicaid during those three (3) months before the expenses can be treated as "Item D" expense. The Hearing Officer determined that there was not factual dispute that the Appellant was not eligible for Medicaid until September 1, 2010 after her cash was placed into a Qualified Income Trust and therefore pursuant to the TennCare policy Memo the Department could not consider expenses before September 1, 2010 as "Item D" expenses. According to the Hearing Officer TennCare, not the Department, determined and establishes policy for TennCare and Medicaid and the Hearing Officer did not have the authority to rule on, contradict, approve, or dispute TennCare's policy. The Hearing Officer further found that the Appellant failed to appeal the January 31, 2010 or the September 19, 2011 notice within forty (40) days and the issue of the use of 2010 liability existed at the time of both notices yet was not raised. As such the Hearing Officer held that the Department's determination of how "Item D" expenses were used is final. The Appellant filed a Petition for Reconsideration of the Initial Order on January 31, 2013. The Hearing Officer entered an Order on February 19, 2013 denying the Appellant's Petition. The Appellant timely filed a Petition for Appeal of the Initial Order on March 4, 2013 with the Commissioner's Designee. A Notice of Receipt of the Petition of Appeal of the Initial Order was mailed on March 5, 2013, giving the parties until 4:30 P.M. on March 15, 2013, to submit written briefs relevant to the issue/s raised in the Petition of Appeal of the Initial Order. The Appellant filed a brief in support of his Petition on March 15, 2013.

In his Petition for Appeal of the Initial Order the Appellant argues that the Hearing Officer was incorrect to rely on the Memo from Patti Killingsworth when reaching the conclusion that TennCare policy considers expenses incurred by an applicant for Medicaid as an "Item D" expenses if incurred during the three (3) months prior to actual eligibility, but imposes a limitation that an applicant be income and resource eligible for Medicaid during those 3 months. The Appellant claims that neither the Medicaid State Plan (Supplement 3 to Attachment 2.6-A) or the TennCare Policy Manual impose a requirement that the Medicaid recipient be income and resource eligible during the three (3) months prior to actual eligibility for a medical expense incurred during that time to qualify as an "Item D" expense. The Appellant contends that the Department cannot rely on the Memo from Patti Killingsworth as it contradicts the TennCare policy Manual and Medicaid State Plan as it relates to determining patient liability.

I find that the Hearing Officer properly relied upon the Policy Memorandum issued by Patti Killingsworth at the Bureau of TennCare on September 9, 2011. Pursuant to *Tenn. Comp. R. & Regs. 1200-13-13-.02(c)*, the Department of Human Services is under contract with TennCare to determine initial eligibility for TennCare Medicaid and TennCare Standard. The Bureau of TennCare is the administrative unit with the responsibility for day-to-day operations of the TennCare program. *Tenn. Comp. R. & Regs. 1200-13-13-.02(b)*. TennCare also is responsible for establishing policy and procedural requirements and criteria for TennCare. *Id.* A Department of Human Services Hearing Official is responsible for conducting hearings properly and promptly in accordance with the rules and regulations established by the Department. *Tenn. Comp. R. Regs. 1240-5—5-.01(1).*

Patti Killingsworth is an Assistant Commissioner of the Bureau of TennCare and Chief of Long Term Care. Her Memo issued on September 9, 2011 is a clarification of TennCare's policy due to changes made to the Medicaid State Plan regarding allowable medical deduction from patient liability (commonly referred to as "Item D"). The Memo states,

> "the recent *State Plan Amendment* clarifies the period of time for which medical expenses incurred prior to the month of application for Medicaid can be deducted from patient liability. Based on the new SPA, only those allowable medical expenses incurred within three months prior to the month of application for Medicaid are **allowed as an Item D expense when the person would have been income and resource eligible at the time the expense was incurred**. Medical expenses incurred more than three months prior to the month of application are disallowed and may not be submitted as an Item D expense. No deduction will be allowed for medical expenses that were incurred as the result of imposition of a transfer of assets penalty period."

Clearly, the Memo from Ms. Killingsworth establishes TennCare policy regarding "Item D" expenses incurred within three (3) months prior to the month of application for Medicaid. Pursuant to the Memo the application would have to have been income and resource eligible at time the "Item D" expense was incurred. Pursuant to Tenn. Comp. R. & Regs. 1200-13-13-.02(b)&(c), the Department of Human Services must determine eligibility for Medicaid according to policies established by TennCare. Additionally, a Department of Human Services Hearing Official has no authority to rule on the validity of a TennCare policy. *See Tenn. Comp. R. Regs. 1240-5—5-.01(1).* There is no factual dispute that the Appellant was not income or resource eligible prior to September 1, 2010. As such the Hearing Officer properly dismissed this portion of the appeal under *Tenn. Comp. 1240-5-3-.04(3) & (6).*

Therefore I find that the Appellant's remaining arguments regarding the Hearing Officer's FINDINGS OF FACT No. 5 and CONCLUSION OF LAW No. 4 (in the Initial Order) are moot and the Hearing Officer properly dismissed this portion of the appeal due to the fact that the Appellant failed to raise a valid factual dispute.

No additional evidence or argument that would alter or reverse the Initial Order was included in the Petition of Appeal of the Initial Order. Following a thorough review of the Hearing Record, I have determined that the decision of the Hearing Officer was fully supported by the testimony and evidence presented. Therefore, the Petition of Appeal of the Initial Order is denied.

This Final Order adopts the decision of the Hearing Officer and incorporates the Findings of Fact and Conclusions of Law contained in the Initial Order entered on the 16th day of February, 2013, as though fully set out herein. This Final Order shall be binding upon the parties to this appeal. If either party is dissatisfied with this decision, a Petition for Reconsideration of the Final Order, specifying in detail the reasons for the request, may be filed with the Department of Human Services within fifteen (15) days from the date of this Order by filing with the Assistant Commissioner, Division of Appeals and Hearings at the following address: State of Tennessee, Department of Human Services, Division of Appeals & Hearings, P.O. Box 198977, Nashville, TN 37219-8977.

Further, an Appellant who is aggrieved by the Final Order may petition for judicial review in Chancery Court of the county of residence or in Davidson County within sixty (60) days of the date of this Final Order.

Entered this the 19th day of March, 2013.

A. Michelle Waldrep

Michelle Waldrep
Assistant Commissioner, Appeals & Hearings

CC: Kerry M. Growdon, Appellant
Robert "Mark" Addison, Attorney for Appellant
Marcia Garner, Director, Medicaid/TennCare Policy, Citizens Plaza Building, 12th Floor
Hearing Officer Initial Orders Mailbox
Pamela Richardson, Program Coordinator, District 4
Susan Bates, Field Management Director 1, District 4
Suzanne Burnett, Field Supervisor 1, District 4, Hamilton County DHS
Elizabeth "Libby" Sponholtz, Hearing Officer, DHS Central Office
Hearing File
Shawn DeHaven, Department Attorney

CERTIFICATE OF SERVICE

I hereby certify that, on March 19, 2013, a copy of the foregoing Order was deposited within the U.S. Mail with sufficient postage affixed thereon to reasonably ensure delivery, addressed to:

Kerry M. Growdon, Appellant, 1000 Tallan Building, 2 Union Square, Chattanooga, Tennessee 37402-2500
Robert "Mark" Addison, Attorney for Kerry M. Growdon, 605 Chestnut Street, Suite 1700, Chattanooga, Tennessee 37450

A. Michelle Waldrep

Michelle Waldrep
Assistant Commissioner, Appeals & Hearings