BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

S[redacted] D[redacted], **Petitioner,**	:	
	:	**Docket No.:**
v.	:	**OSAH-DFCS-AMN-[redacted]-11-Wood**
	:	
DHS, FAMILY & CHILDREN SERVICES **Respondent.**	:	**Agency Reference No.:** [redacted]

FILED
OSAH
AUG 07 2015

Victoria Hightower, Executive Assistant

INITIAL DECISION

Wood, Judge.

I. Introduction

Petitioner S[redacted] D[redacted], by and through Shawanda Dent, her personal representative, appealed Respondent's denial of her application for Medicaid coverage under the ABD Medically Needy (AMN) Class of Assistance for the month of September 2014. An evidentiary hearing was held before the undersigned Administrative Law Judge at the Bibb County Courthouse in Macon, Georgia on July 22, 2015. Ms. Dent participated in the hearing as Ms. D[redacted]'s personal representative, and Ms. Geraldine Reese, a DFCS caseworker, appeared for Respondent. For the reasons stated herein, Respondent's decision is **REVERSED**.

II. Findings of Fact

1. Ms. D[redacted] was hospitalized at Coliseum Medical Center from August 29 through September 14, 2014, during which time she incurred approximately $160,000.00 in medical bills. *Testimony of Shawanda Dent.*

2. Ms. Dent applied for Medicaid benefits on Ms. D[redacted]'s behalf on September 5, 2014. *Petitioner's Exhibit 3; Testimony of Shawanda Dent.*

3. Respondent initially denied Ms. D[redacted]'s application on October 2, 2014 because her application for Supplemental Security Income had yet to be approved or denied by the Social Security Administration. *Petitioner's Exhibit 3.*

4. In a Notice of Decision dated May 20, 2015, Respondent advised Ms. Dent that it had found Ms. D[redacted] eligible for retroactive Medicaid coverage for August 2014. However, Respondent determined that Ms. D[redacted] was not entitled to Medicaid coverage for September 2014, the month of application. *Petitioner's Exhibit 1.*

5. Respondent cited a revised interpretation of Medicaid policy in support of its determination to deny Ms. D[redacted] Medicaid coverage for the month of application. This revised interpretation

was set forth in a memorandum generated by Respondent's Medicaid Program & Policy Unit on December 10, 2014 and thereafter distributed to Medicaid eligibility personnel. According to the memorandum, Respondent would no longer approve reimbursement for "intervening months", i.e., the period between submission and approval of the Medicaid application. Rather, effective immediately, Respondent would make eligibility determinations only as to the three-month period preceding the month of application. Respondent's revision of its eligibility policy was based on its interpretation of federal law governing "retroactive Medicaid" to allow Medicaid coverage "only [for] the three months prior to the month of application." According to Respondent's revised policy interpretation, Ms. D[redacted] was eligible for Medicaid coverage for August 2014, the month prior to her application, but not September 2014, the month in which she submitted her application. *Petitioner's Exhibit 1; Respondent's Exhibit 1*; *Testimony of Geraldine Reese.*

III. Conclusions of Law

Based on the above findings of fact, the undersigned makes the following conclusions of law:

1. Medicaid is a joint federal-state program that provides comprehensive medical care for certain classes of eligible recipients whose income and resources are determined to be insufficient to meet the costs of necessary medical care and services. 42 U.S.C. §§ 1396 et seq.; *Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011). Participation is voluntary, "but once a state opts to participate it must comply with federal statutory and regulatory requirements." *Id.* All states have opted to participate and, thus, each must designate a single state agency to administer its Medicaid plan. *Id.*; 42 C.F.R. § 431.10(a), (b)(1). In Georgia, applicants may apply for Medicaid through Respondent, which issues guidelines on Medicaid eligibility in its Medicaid Manual.

2. Pursuant to the Medicaid Act, a state Medicaid plan must

> provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished *in or after the third month before the month in which he made application* . . . if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished.

42 U.S.C. § 1396a(a)(34) (emphasis added). Further, federal regulations governing retroactive Medicaid prescribe that eligibility for Medicaid must be made effective "no later than the third month before the month of application if the individual

> (1) Received Medicaid services, at any time during that period, of a type covered under the plan; and
> (2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

42 C.F.R. § 435.915(a).

3. According to Respondent's interpretation of the governing law, an individual is entitled to receive reimbursement for covered expenses incurred for three months before he or she applied to the program and would be covered for services after approval of his or her application, but could not obtain reimbursement for covered expenses incurred between those two periods. *See* Conlan v. Shewry, 131 Cal. App. 4th 1354, 1379 (Cal. App. 2005) (rejecting such an interpretation). However, according to the clear and unambiguous language of the Medicaid Act and the pertinent regulatory provision, Medicaid reimbursement must be made available during the three-month period preceding the application *and* the application processing period. *See* 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a).

4. The Medicaid Act requires that Medicaid benefits be made available to eligible individuals for covered services "furnished *in or after* the third month before the month" of application. 42 U.S.C. § 1396a(a)(34) (emphasis added). The Act thus sets forth a beginning date for retroactive Medicaid—three months before the application month—and mandates that assistance remain available for services furnished thereafter. Moreover, the governing regulatory provision's directive that eligibility begin "no later than the third month before the month of application," in the absence of a prescribed end date for eligibility, warrants the conclusion that the individual remains eligible through the application processing period. Accordingly, where an individual applies for Medicaid in September, Respondent is required to ensure that services are available to the individual for services furnished in June—the third month before the month of application—and ongoing, provided that other criteria for retroactive Medicaid are satisfied. *See Liegl v. Webb*, 802 F.2d 623, 625 (2d Cir. 1986) ("Under 42 U.S.C. § 1396a(a)(34), a State that chooses to provide Medicaid coverage to the medically needy is required to make such assistance available on both a prospective and retroactive basis . . . ."); *Keup v. Wis. Dep't of Health & Family Servs.*, 675 N.W.2d 755, 759 n.6 (2004) (interpreting retroactive Medicaid to include "the time period prior to the determination that [the applicant] was eligible to be a recipient of medical assistance benefits.").

IV. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, it is the Initial Decision of the undersigned that Respondent's decision to deny Petitioner's application for Medicaid benefits for the month of September 2014 is **REVERSED**.

SO ORDERED this 7th day of August, 2015.

MAXWELL WOOD
Chief Administrative Law Judge

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

S[redacted] D[redacted], Petitioner,	:	
v.	:	Docket No.: OSAH-DFCS-AMN-[redacted]11-Schroer
DHS, FAMILY & CHILDREN SERVICES, Respondent.	:	Agency Reference No.:[redacted]

NOTICE OF INITIAL DECISION

This is the Initial Decision of the Administrative Law Judge (Judge) in the case. This decision is reviewable by the Referring Agency. If a party disagrees with this decision, the party may file a motion for reconsideration, a motion for rehearing, or a motion to vacate or modify a default order with the OSAH Judge. A party may also seek agency review of this decision.

FILING A MOTION WITH THE JUDGE AT OSAH

The Motion must be filed in writing within ten (10) days of the entry, i.e., the issuance date, of this decision. **The filing of such a motion may or may not toll the time for filing a request for agency review.** ***See*** OSAH Rules 616-1-2-.28 and .30 in conjunction with O.C.G.A. § 49-4-153. Motions must include the case docket number, be served simultaneously upon all parties of record, either by personal delivery or first class mail, with proper postage affixed, and be filed with the OSAH clerk at:

Clerk
Office of State Administrative Hearings
Attn.: Victoria Hightower, vhightower@osah.ga.gov
225 Peachtree Street, NE, South Tower, Suite 400
Atlanta, Georgia 30303-1534

REQUEST FOR AGENCY REVIEW

A request for Agency Review must be filed within thirty (30) days after service of this Initial Decision. O.C.G.A. § 49-4-153(b)(1). A copy of the application for agency review must be simultaneously served upon all parties of record and filed with the OSAH clerk. The application for Agency Review should be filed with:

Department of Community Health
Legal Services Unit, Attn: Appeals Reviewer
2 Peachtree Street, 40th Floor
Atlanta, Georgia 30303

This Initial Decision will become the Final Decision of the agency if neither party makes a timely application for agency review. O.C.G.A. § 49-4-153(b)(1) and (c). When a decision becomes Final, an application for judicial review must be filed within thirty (30) days in the Superior Court of Fulton County or the county of residence of the appealing party. If the appealing party is a corporation, the action may be brought in the Superior Court of Fulton County or the superior court of the county where the party maintains its principal place of doing business in this state. O.C.G.A. § 49-4-153(c).