BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

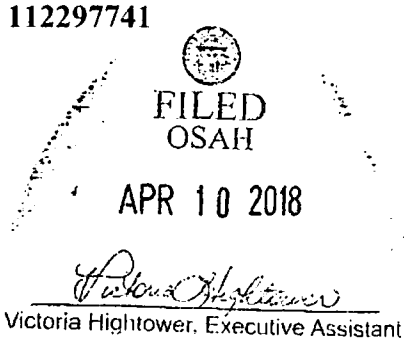
JEAN WETHERINGTON,
Petitioner,

v.

DHS, DIVISION OF FAMILY AND CHILDREN SERVICES,
Respondent.

Docket No.: 1822385
1822385-OSAH-DFCS-M-NH-36-Schroer

Agency Reference No.: 112297741



INITIAL DECISION

I. INTRODUCTION

Petitioner Jean Wetherington requested a hearing after the Department of Human Services, Division of Family and Children Services (hereinafter "Respondent" or "DFCS") failed to timely process her application for Medicaid benefits, resulting in the loss of benefits from July through December 2017. The undersigned administrative law judge conducted pre-hearing conference on February 5, 2018. Patrick C. Smith, Jr., Esq., represented Petitioner in this matter. Felicia Scott, a DFCS caseworker, appeared on behalf of Respondent. Following the hearing, the record remained open to allow the parties to file post-hearing briefs. Petitioner filed her brief on February 16, 2018. Respondent did not file a response to Petitioner's brief.[1]

Based on the evidentiary record and the arguments of the parties, DFCS's action is **REVERSED** and **REMANDED** for the reasons stated below.

II. FINDINGS OF FACT

1. Petitioner is a resident of Westwood Extended Care Facility (hereinafter "Westwood"), a nursing home.

2. Petitioner, through Westwood, applied for Medicaid under the Nursing Home class of assistance

[1] Petitioner initially failed to serve a copy of her post-hearing brief on Respondent. Consequently, the Court granted Respondent additional time to respond.

on July 11, 2017. (Petitioner's Exhibit B).

3. DFCS submitted a "Verification Checklist" to Westwood on or about September 26, 2017 (Petitioner's Exhibit C).

4. In a "Notice of Decision" dated November 6, 2017, DFCS notified Petitioner that it denied her Medicaid application because her resources, which consisted of accumulated income, exceeded program limits. (Petitioner's Exhibit A, B).

5. According to Petitioner, she allowed her income to accumulate because she was incorrectly instructed not to pay her patient liability during the pendency of her Medicaid application.[2] Petitioner generated a spreadsheet showing her accumulated income by month and attached it to her post-hearing brief. According to notations on this spreadsheet, Petitioner paid $6,000 to Westwood in December 2017. As a result, her resources were within program limits as of January 1, 2018. (Petitioner's Exhibit A).

6. In her post-hearing brief, Petitioner acknowledged that she was over the resource limit from July through December 2017. However, she averred that she was nonetheless entitled to Medicaid benefits for at least some of those months because, had DFCS notified her of the deficiency in accordance with prescribed standards of promptness, she would have paid her patient liability and thereby become financially eligible for Medicaid. Specifically, Petitioner asserted that if she was notified she was over the resource limit by August 25, 2017, the last day of the forty-five-day standard of promptness, she would have been eligible for Medicaid as of September 1, 2017. Petitioner requested that the Court order Respondent to process her application as though her resources were within program limits as of July 11, 2017 or, alternatively, as of September 1, 2017. (Petitioner's Exhibits A, B).

III. CONCLUSIONS OF LAW

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

[2] The source of this information is unclear from the Petitioner's brief.

1. Because this matter concerns the denial of Petitioner's Medicaid application, Petitioner bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4). In rendering a decision with respect to a contested case, the Court has all the powers of the referring agency. O.C.G.A. § 50-13-41: see also Upper Chattahoochee Riverkeeper, Inc. v. Forsyth Cty., 318 Ga. App. 499, 506 (2012).

2. 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." Moore, 637 F.3d at 1232. 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, Respondent is the entity responsible for processing Medicaid applications.[3]

3. Pursuant to the Medicaid Act, state plans for medical assistance must "provide that all individuals wishing to make application for medical assistance under the plan shall have an opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396(a)(8); see also 42 C.F.R. § 435.930(a) ("The agency must . . . [f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures[.]"). Federal regulations implementing the Medicaid Act specify that the time for rendering eligibility determinations may not exceed 90 days for individuals who apply for Medicaid on the basis of disability and 45 days for all other applicants. 42 C.F.R. § 435.912(c)(3). Thus, the timeliness provisions in the Medicaid Act and the implementing regulations guarantee two categories of rights: "First, that Medicaid assistance be furnished with reasonable promptness to all eligible individuals," and

3 The Medicaid Manual is available to the public at http://odis.dhs.ga.gov/ChooseCategory.aspx?cid=1037.

second "that the agency make reasonably prompt claims determinations." Susan J. v. Riley, 254 F.R.D. 439, 452 (M.D. Ala. 2008); see Doe by & Through Doe v. Chiles, 136 F.3d 709, 719 (11th Cir. 1998). In accordance with this guarantee, Respondent provides in its Medicaid Manual that, for aged and blind applicants, Medicaid applications should be processed within "45 calendar days beginning with the application date . . . ." Dep't of Human Servs., Economic Support Services Manual, Volume II, Section 2060-5.

4. In the present case, Respondent failed to render an eligibility determination within the time limits prescribed by the Medicaid Act and implementing regulations. Pursuant to 42 C.F.R. 435.912(c)(3)(ii) and Section 2060 of the Medicaid Manual, Respondent had 45 days to render such a determination. But Respondent did not inform Petitioner of her ineligibility until November 6, 2017, approximately 73 days after the August 25, 2017 deadline. See Forman v. State Dep't of Children & Families, 956 So. 2d 477, 479–80 (Fla. Ct. App. 2007) (recognizing agencies' affirmative duty to inform applicants of conditions relevant to eligibility). As a direct consequence of Respondent's failure, Petitioner was denied months of coverage to which she would have been entitled. See Salazar v. District of Columbia, 954 F. Supp. 278, 325 (D.D.C. 1996) ("[The] failure to process Medicaid applications within the requisite 45 days is not simply an abstract bureaucratic irregularity. Rather it has concrete and often-times devastating effects on poor, sick, vulnerable people.").

5. However, Petitioner has not shown that she is entitled to Medicaid benefits for July or August. As Respondent was not obligated to inform Petitioner of her financial ineligibility until August 25, 2017, Petitioner would have remained ineligible during those months even if Respondent had complied with the standard of promptness.

6. Accordingly, the Court concludes that the most appropriate and narrowly-tailored remedy is to remand this matter to Respondent with directions to review Petitioner's July 11 Medicaid application

and evaluate her eligibility based on the resources available to her as of January 1, 2018. If after conducting this review Respondent determines that Petitioner would have been eligible for Medicaid, Respondent shall provide Medicaid coverage effective September 1, 2017. See 42 C.F.R. § 431.246 ("The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken . . . if . . . [t]he hearing decision is favorable to the applicant or beneficiary[.]"); French v. Dep't of Children & Families, 920 So. 2d 671, 675 (Fla. Ct. App. 2006) ("'[A]ll participating states are required to have state procedures whereby applicants and recipients denied assistance may appeal that decision and, if they prevail at the hearing, receive benefits retroactive to the time of the incorrect decision.'" (quoting Randall v. Lukhard, 709 F.2d 257, 269 (4th Cir. 1983))).

IV. DECISION

In accordance with the foregoing Findings of Fact and Conclusions of Law, DFCS's decision to deny Petitioner's Medicaid application is **REVERSED**. This matter is **REMANDED** to Respondent for reevaluation of Petitioner's July 11, 2017 Medicaid application in accordance with the above directives.

SO ORDERED, this 10th day of April, 2018.

Kimberly W. Schrader
Administrative Law Judge

NOTICE OF INITIAL DECISION

Attached is the Initial Decision of the administrative law judge. A party who disagrees with the Initial Decision may file a motion with the administrative law judge and/or an application for agency review.

Filing a Motion with the Administrative Law Judge

A party who wishes to file a motion to vacate a default, a motion for reconsideration, or a motion for rehearing must do so within 10 days of the entry of the Initial Decision. Ga. Comp. R. & Regs. 616-1-2-.28, -.30(3). All motions must be made in writing and filed with the judge's assistant, with copies served simultaneously upon all parties of record. Ga. Comp. R. & Regs. 616-1-2-.04, -.11, -.16. The judge's assistant is Victoria Hightower - 404-651-9643; Email: vhightower@osah.ga.gov; Fax: 404-818-3724; 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303.

Filing an Application for Agency Review

A party who seeks review by the referring agency must file an application for agency review within 30 days after service of the Initial Decision. O.C.G.A. §§ 50-13-17(a), -41(e). **In nearly all cases, agency review is a prerequisite for judicial review.** O.C.G.A. § 50-13-19(a).

The application for agency review must be filed with: **Office of General Counsel, Attn: Appeals Reviewer, Georgia Department of Human Services, 2 Peachtree Street NW, 29th Floor, Atlanta, Georgia 30303.** Copies of the application for agency review must be served upon all parties of record and filed simultaneously with the OSAH Chief Clerk at 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303. If a timely application for agency review is not filed and the referring agency does not review the Initial Decision on its own motion, the Initial Decision will become the Final Decision of the referring agency by operation of law. O.C.G.A. §§ 50-13-17(a), -41(e).

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