BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
G. S.-Q.	)	OAH No. 21-2504-MDE
	)	

DECISION

I. Introduction

G. S.-Q. is a Long-Term Care Medicaid recipient who resides in Health Center A (HC-A), where she receives an Intermediate Care Facility level of care. The Division of Public Assistance (Division) determined that she had a monthly cost of care (COCA) obligation of $2,111.10 beginning with the month of June 2021. Ms. S.-Q. requested a hearing to challenge that determination because she had debts for non-prescription medications and supplies and for residential/care charges that were incurred prior to her approval for Long-Term Care Medicaid.

Ms. S.-Q.'s hearing was held on December 13, 2021 and January 6, 2022. Ms. S.-Q. represented herself. K. J., a case manager at HC-A, assisted Ms. S.-Q.. Sally Dial, a Division Fair Hearing Representative, represented the Division.

The undisputed facts of this case show that there are two types of expenses at issue. With regard to the first type of expense, the incurred expenses for non-prescription medications, those are disallowed because there was no documentation showing how those expenses were covered by Medicare. As a general rule, in order for Medicaid to allow a COCA deduction for a Medicaid recipient who is also a Medicare recipient, those expenses will only be covered by Medicaid if those expenses are not covered by Medicare. Because there was no documentation showing how Medicare handled these expenses and showing that they were medically necessary, they are disallowed. The second expense consists of the HC-A charges incurred by Ms. S.-Q. before she was approved for Long-Term Care Medicaid. As discussed in detail below, those expenses are approved.

II. Undisputed Facts

Ms. S.-Q. is a Medicare recipient who was admitted to Health Center A (HC-A) in late August of 2020, pursuant to a physician's orders that directed that she be placed in long-term care at the Intermediate Care Facility level of care.[1] Health Center A provides an Intermediate

[1] Exs. 8.3 – 8.4

Care Facility (ICF) level of care to Ms. S.-Q.. Ms. S.-Q. does not receive skilled nursing services or professional therapies there on a daily basis. She is charged a monthly flat fee for her residence at HC-A which includes room, board, and oversight care, which can include physical assistance with her activities of daily living and nursing care, but it does not include skilled nursing care.

Ms. S.-Q. did not apply for Medicaid until May of 2021.[2] She was approved for Medicaid Long-Term Care effective February 1, 2021.[3] She incurred substantial unpaid bills to HC-A that predate her approval for Medicaid. Those consist of $126,274 for HC-A's residential/care charges and $1,717.17 in uncovered pharmacy charges.[4] Ms. S.-Q. did not submit her HC-A residential/care charges to Medicare for approval. The uncovered pharmacy charges were primarily for over-the-counter medications (acetaminophen, antacids, etc.) not covered by insurance, with some for medications with co-pays. According to information provided by HC-A, those bills were submitted to Ms. S.-Q.'s Medicare Part D insurer. However, Ms. S.-Q. did not have any explanation of benefits (EOB) regarding those submissions and how they were handled by her insurer:

> All the medications were billed to her Part D insurance, but the EOBs were mailed to a different address and we do not have access to them. We will try to have the insurance resend them, but I doubt they would be back in time.[5]

After Ms. S.-Q. was approved for Long-Term Care Medicaid coverage, the Division notified her that she had a monthly COCA obligation in the amount of $2,111.10 beginning in June of 2021. In calculating the obligation, the Division used her monthly Social Security income of $2,345.50 and allowed her two deductions. Those deductions were for a $200 personal needs allowance and $34.40 for her Medicare Part D monthly premium.[6]

In July 2021, Ms. S.-Q. requested that she receive deductions from her COCA obligations for her HC-A residential/care charges and uncovered pharmacy charges.[7] The Division initially denied that request on August 11, 2021.[8] There was subsequent correspondence, where the Division requested that Ms. S.-Q. provide it with documentation showing that the charges were

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2 Exs. 2.2 – 2.5.
3 Exs. 2 – 2.1, 3.1.
4 Ex. 8.5.
5 *See* nursing home email to the Division hearing representative dated January 5, 2022, filed on January 6, 2022.
6 Ex. 3.
7 Ex. 4.
8 Ex. 4.2.

not "subject to payment by a third party, such as Medicare, A, B, D, or any private insurance."[9] HC-A's response, on Ms. S.-Q.'s behalf, was that HC-A's residential/care charges were not submitted to Medicare because Medicare does not pay for ICF level of care charges, and that it did not currently have an explanation of benefits for the uncovered pharmacy charges. In that same response, HC-A stated it did not have a letter from the doctor showing the medical necessity for the medications.[10]

The Division denied Ms. S.-Q.'s request for coverage of the uncovered pharmacy expenses because it did not have proof that the expenses were medically necessary and that they were not covered by a third-party such as Medicare. It denied the request for coverage of the uncovered HC-A residential/care charges because it deemed the room and board component of the charge as being medically unnecessary.[11]

III. Discussion

The Alaska Medicaid program contains a variety of coverage categories. *See* 7 AAC 100.002. Each of these categories has different financial requirements. Ms. S.-Q. receives Medicaid Long-Term Care benefits. As a Long-Term Care recipient who lives in a nursing home, she is allowed a personal needs allowance of $200.00 per month.[12] If her income exceeds that amount, she is responsible for paying the excess to her medical providers, which reduces the amount the Medicaid program pays to those providers. That amount she is required to pay is referred to as the Medicaid Cost of Care (COCA) contribution.[13]

Ms. S.-Q.'s normal monthly income consists of $2,345.50 in Social Security benefits. Her normal monthly COCA obligation would be the difference between that amount and the $200.00 personal needs allowance. However, a Medicaid recipient who is subject to the Cost of Care obligation is entitled to some deductions when calculating that obligation. It is undisputed that Ms. S.-Q. has $34.40 Medicare Part D premium which was allowed as a deduction by the Division. Applying the two deductions (personal needs allowance of $200.00 and Medicare Part D premium of $34.40) results in a COCA of $2,111.10 per month, which is the amount the Division notified Ms. S.-Q. was her COCA beginning with the month of June 2021.

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9 Ex. 4.3.
10 Ex. 5.1.
11 Ex. 10.
12 Ex. 11.5.
13 7 AAC 100.552; 7 AAC 100.554(a) and (c)(1); 7 AAC 100.558; Ex. 12.4.

Allowable deductions also include unpaid medical deductions.[14] The deduction applies to "medical expenses incurred by the recipient that are not paid by Medicaid, Medicare, or any other health insurance."[15] Ms. S.-Q. has substantial unpaid bills associated with her residency at HC-A which fall into two areas: one is uncovered pharmacy bills and the other is unpaid residential/care charges. Both sets of charges predate the effective date of Ms. S.-Q.'s Medicaid Long-Term Care approval.

A. Does Medicaid Allow a COCA for Medical Expenses that Predate Approval?

The first issue which must be resolved relates to the fact that the requested deductions are for expenses that predate February of 2021, the starting month of Ms. S.-Q.'s Medicaid Long-Term Care coverage. The Medicaid regulation which addresses this issue is 7 AAC 100.566. It reads, in pertinent part:

> (a) The unpaid medical expense allowance is a deduction from the total monthly income of the recipient for the purpose of keeping that income available to the recipient to cover any outstanding medical expenses incurred by the recipient that are not paid by Medicaid, Medicare, or any health insurance.

The regulation, on its face, refers to "outstanding medical expenses." There is no language in the regulation that limits the availability for that deduction to medical expenses incurred only after the recipient's approval for Medicaid coverage. As such, this deduction is available for uncovered outstanding medical expenses, such as Ms. S.-Q.'s, that predate her approval for Medicaid Long-Term Care coverage.

B. Uncovered Pharmacy Charges

The uncovered pharmacy billings do not have any support showing that the underlying medications were medically necessary, nor is there any documentation showing how they were treated by Ms. S.-Q.'s Medicare Part D provider. As such, Ms. S.-Q. has not met her burden of proof to satisfy the requirements for Medicaid to allow these as unpaid medical expenses. Ms. S.-Q.'s request is therefore denied at this time. She may resubmit her claims. If she resubmits her claims for uncovered pharmacy charges and they are denied, either partially or entirely, she may request a new hearing to challenge that denial.

C. Nursing Home Residential/Care Charges

1. Submission to Medicare

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[14] 7 AAC 100.554(c)(5).
[15] 7 AAC 100.566(a).

It is undisputed that Ms. S.-Q.'s charges for her nursing home residency and care were not submitted to Medicare. The applicable regulation 7 AAC 100.566(a) provides that Medicaid will only provide coverage for unpaid medical expenses that are not covered by Medicare or other coverage. Ms. S.-Q.'s only coverage, other than Medicaid, is her Medicare and her Medicare Part D. In answering the question of whether Ms. S.-Q. must first submit her nursing home care charges to Medicare prior to submitting them to Medicaid, it is necessary to examine what those charges are for.

Ms. S.-Q. is residing in HC-A, where she receives an ICF level of care. Intermediate Care is defined by Alaska regulations as the "observation, assessment and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation."[16] Intermediate Care services are "provided to a recipient who does not require the level of care provided by a skilled nursing facility."[17] Medicare allows payment for skilled nursing residential care. In order to meet the requirements for skilled nursing residential care, there must be a requirement for daily skilled nursing or skill rehabilitation services, for a condition that the recipient received inpatient services, and that can only be provided in a skilled nursing facility.[18] Medicare defines any type of care other than skilled nursing facility level of care as custodial care. It does not provide coverage for custodial care.[19] Because Ms. S.-Q. is not receiving a skilled nursing facility level of care, she is receiving what Medicare classifies as custodial care. Custodial care is not covered by Medicare. Because the Medicare regulations are exceedingly clear that Medicare will not cover Ms. S.-Q.'s custodial care charges, it is not necessary for her to first submit them to Medicare. Consequently, because her nursing home charges are not covered by Medicare, they are eligible to be covered by Medicaid.

2. Medical Necessity

The Division has also posited that Ms. S.-Q.'s residential/care charges are not entirely medically necessary. Its position is based upon the fact that HC-A has a flat charge for its services which include room and board, assistance with activities of daily living, and medical

[16] 7 AAC 140.510(b).
[17] 7 AAC 140.510(a)(3).
[18] 42 CFR §§ 409.30 – 409.35.
[19] 42 CFR § 411.15(g). There is an exception for hospice care. 42 CFR § 411.15(g) and (k)(2). However, Ms. S.-Q. is not receiving hospice care, so she would not fall under this exception.

care such as routine nursing services. One of the foundational requirements for Medicaid coverage is that Medicaid will only pay for medically necessary services.[20] The Division therefore submits that the portion of Ms. S.-Q.'s residential/care charges which is attributable to her room and board is not medically necessary and cannot be covered by Medicaid. HC-A charges a flat daily fee for its services; it does not have a way to break them down. That rate is a day rate which is set by the Department's Office of Rate Review. [21]

The Division's argument is not entirely implausible. Room and board are not what one would consider to be medical treatment, per se. However, Medicaid pays for intermediate care facilities if an applicant is approved for Long-Term Care coverage.[22] It pays a daily rate for all inclusive care, less a recipient's COCA obligation.[23] Because Medicaid does not pay for medically unnecessary services, it therefore considers long-term care residential care services, inclusive of room and board, as medically necessary. As such, Ms. S.-Q.'s preexisting obligation to her nursing home charges is medically necessary.

D. COCA Amount

As discussed above, Ms. S.-Q.'s uncovered pharmacy charges are not allowed for the purposes of providing Ms. S.-Q. with a deduction from her COCA obligation. However, her uncovered obligation to HC-A in the amount of $126,274 is allowed. Because this is a large amount that cannot possibly be paid within a one month's period of time, it is allocated over time:

> If the outstanding debt is larger than the maximum medical expense allowance for the month, an additional monthly medical expense allowance may be given for subsequent months until the accumulated allowances equal the entire unpaid medical expense. Once the cumulative allowances have covered the entire unpaid medical expense, no further allowances may be given for that unpaid medical expense, even if the recipient has failed to pay off the debt.[24]

Ms. S.-Q.'s income as of June 2021, the first month that the Division subjected her to a COCA requirement, was $2,345.50 in Social Security benefits. Her normal monthly COCA obligation would be the difference between that amount and the $200.00 personal needs

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20 *See* 7 AAC 105.100 and 7 AAC 105.110.

21 *See* 7 AAC 150.010 *et. seq.* The parties are directed to the list of current Medicaid daily payments for approved Long-Term Care facilities (https://dhss.alaska.gov/Commissioner/Documents/RateReview/Rate-Memo-20220101.pdf - dated accessed January 25, 2022).

22 7 AAC 100.500 *et. seq.*

23 7 AAC 145.640, 7 AAC 145.650, and 7 AAC 145.670.

24 7 AAC 100.566(b).

allowance. It is undisputed that Ms. S.-Q. has $34.40 Medicare Part D premium which was allowed as a deduction by the Division. Applying the two deductions (personal needs allowance of $200.00 and Medicare Part D premium of $34.40) results in a remaining amount of $2,111.10 per month. This amount is therefore allocated to her unpaid HC-A residential/care charge of $126,274. Because this amount is greatly in excess of $2111.10, it reduces her COCA obligation to $-0-. At her income level as of June 2021, she would have her COCA obligation set to zero for 60 months beginning with the month of June 2021.[25] The parties should be aware that because Ms. S.-Q.'s income and authorized medical deductions could change, that this could result in an adjustment in her COCA obligation over time.

IV. Conclusion

The Division's determination that Ms. S.-Q. is not entitled to a deduction for COCA calculation purposes for her uncovered pharmacy costs is AFFIRMED. However, as set forth above, she is entitled to the allowance of her outstanding residential/care charges in the amount of $126,274, and the Division's determination denying that deduction is REVERSED.

Dated: January 26, 2022

SIGNED
Lawrence A. Pederson
Administrative Law Judge

[25] $126,274 divided by $2,111.10 is 59.81 months.

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 3rd day of March, 2022.

By: SIGNED
Name: Jillian Gellings
Title: Project Analyst, DHSS

[This document has been modified to conform to the technical standards of publication. Names have been changed to protect privacy.]