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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

E.Z.,	:	
PETITIONER,	:	**ADMINISTRATIVE ACTION**
V.	:	**FINAL AGENCY DECISION**
DIVISION OF MEDICAL ASSISTANCE	:	**OAL DKT. NO. HMA 3503-2014**
AND HEALTH SERVICES &	:	
GLOUCESTER COUNTY BOARD OF	:	
SOCIAL SERVICES,	:	
RESPONDENTS.	:	

As Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this matter, consisting of the Initial Decision, the documents in evidence and the contents of the OAL case file. No exceptions were filed in this matter. Procedurally, the time period for the Agency Head to render a Final Agency Decision is September 9, 2014 in accordance with an Order of Extension.

This matter concerns Petitioner's eligibility for the Global Options (GO) waiver program. She has resided at Washington Township Senior Living, an assisted living facility (ALF), since 2010. She filed an application on July 19, 2013 and paid privately through August 2013. As a condition of receiving benefits under GO, Petitioner must meet financial and clinical eligibility as well as be in need of waiver services. There is no provision for receiving waiver benefits prior to the later of these two dates. Petitioner's eligibility was determined to be October 24, 2013.

The Initial Decision modified Petitioner's eligibility to be September 15, 2013 under an equitable doctrine by finding the October 24, 2013 date was set by a "procedural mistake that was out of her control." ID at 6. That date was set as approximately fifteen days from the date on the ALF's request to have Petitioner clinically evaluated.[1] For the reasons that follow, I hereby REVERSE the Initial Decision and reinstate the October 24, 2013 date.

First and foremost, the prohibition of retroactive eligibility for GO services cannot be ignored. Home and Community based waiver programs, such as the GO waiver, are not entitlement programs since all persons who are eligible for Medicaid State Plan services are not entitled to waiver services. Though waivers must be approved by CMS, States retain great latitude in determining the composition and construction of a waiver. Indeed the States, at their option, may waive the requirements of 42 U.S.C.A. §1396a(a)(1), §1396a(a)(10)(B), or §1396a(a)(10)(C)(i)(III) of the Act, which concern respectively, statewide application of Medicaid, comparability of services, and income and resource rules

[1] If Petitioner's plan with the ALF was to establish GO eligibility as of September 1, 2013, which was a Sunday; it is bewildering why the ALF waited until August 28, 2013 to complete the AL-6.

applicable to individuals living in the community and set a cap on the number of waiver slots.

In order to determine medically necessary services in a nursing home or pursuant to a home and community based waiver requiring nursing home level of care, a pre-admission screening is completed by "professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." N.J.A.C. 8:85-2.1(a). See also, N.J.S.A. 30:4D-17.10, et seq. This must be done prior to receipt of benefits so as not to create a program in the community using the higher income level. To that end, Petitioner's eligibility under this program permits a higher income level - 300 percent of the SSI benefit amount or $2,130 when she applied in 2013. Cf. 42 U.S.C.A. § 1396 and 1396a(30). As the income level was $958 for New Jersey Care, Petitioner's income of $1,529.50 rendered her ineligible for any other Medicaid program but GO. CWA-1. See Medicaid Communication NO. 13-01.

The waiver regulations clearly state that "[r]etroactive eligibility is not available to waiver program beneficiaries; no waiver service provided prior to the date of enrollment shall be considered for reimbursement." N.J.A.C. 10:49-22.1. As such, Petitioner needed to meet clinical eligibility for GO waiver program as set by Federal rules. Those rules require an evaluation of need as well as counseling regarding alternatives including the choice of receiving services in a nursing facility or community setting be done prior to entry into the waiver. 42 C.F.R. § 441.302(c) and (d) and 42 C.F.R. § 441.303(d). Clinical eligibility for GO waiver services requires that an individual must be assessed by the State and meet nursing facility level of care. N.J.A.C. 8:85-2.1(a), the regulation

addressing nursing home level of care, specifically states that: "Eligibility for nursing facility (NF) services will be determined by the professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." Clinical eligibility is established in real time through an assessment of medical conditions.

Additionally, prior to furnishing services under the waiver, there must be a "written plan of care based on an assessment of the individual's health and welfare need and developed by qualified individuals for each recipient under the waiver." 42 C.F.R. § 441.352(f). In this case, Petitioner's eligibility is governed by those rules and her eligibility for GO can only exist after these pre-requisites are met.

As the pathway to establish GO eligibility is clear, Petitioner cannot be given eligibility based on equitable grounds. In Office of Personnel Management v. Richmond, 496 U.S. 414, 110 S. Ct. 2465, 110 L.Ed. 2d 387 (1990), the United States Supreme Court held that, under the Appropriations Clause of the Constitution, the payments of benefits from the federal treasury are limited to those authorized by statute. Erroneous advice from a governmental employee regarding federal disability benefits cannot estop the government from denying benefits not permitted by law. Article VIII, Section II of the New Jersey Constitution also has a similar appropriations language. As the Medicaid Program is a cooperative federal-state program, jointly financed with federal and state funds, payment of Medicaid benefits from the state and federal treasuries must be authorized by law. See also Johnson v. Guhl, 357 F. 3d 403,409-10 (3rd Cir. 2004) citing an 1868 Supreme Court case which held that "the Government

could not be compelled to honor bills of exchange issued by a government official where there was no statutory authority for the issuance of the bills" and Gressley v. Califano, 609 F.2d 1265, 1267 (7th Cir.1979) in which the Seventh Circuit elaborated on the general rule, stating "[t]he government could scarcely function if it were bound by its employees' unauthorized representations. Where a party claims entitlement to benefits under federal statutes and lawfully promulgated regulations, that party must satisfy the requirements imposed by Congress. Even detrimental reliance on misinformation obtained from a seemingly authorized government agent will not excuse a failure to qualify for the benefits under the relevant statutes and regulations."

Medicaid has sought to work with ALFs so as to have clinical eligibility be determined concurrently with financial eligilbity. In February 2011, the Department of Health and Senior Services, which oversaw the GO waiver at the time, issued guidance to ALFs that permitted the facility to ask for clinical review by submitted an AL-6 form to the Office of Community Choice Options (OCCO) when the resident is anticipating financial eligibility within the next three to six months. http://www.state.nj.us/humanservices/doas/documents/policy/al_afc_referral_form.pdf. OCCO-1 at 43. As the ALF did not appear at the hearing, it is unclear why the facility waited to request clinical review until after the financial Medicaid application was filed if the ALF had been working with Petitioner on spending down her resources. ID at 2. The clinical review could have been requested at the time the financial application was filed. To compound the delay by the ALF, the facility sent the request to the wrong office. There is no indication that the ALF followed up with OCCO which would have revealed the mistake.

As the aforementioned clinical factors and waiver requirements must be met prior to entry in the GO waiver program, Petitioner is not entitled to benefits prior to that happening. Thus, I FIND her GO eligibility date must stand at October 24, 2013.

THEREFORE, it is on this 8th day of SEPTEMBER 2014

ORDERED:

That the Initial Decision in this matter is hereby REVERSED; and

That the October 24, 2013 eligibility date remains unchanged.

Valerie Harr, Director
Division of Medical Assistance
and Health Services