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IN THE
COURT OF APPEALS OF INDIANA

Indiana Family and Social Services Administration, *Appellant-Defendant*, v. Lance Patterson, *Appellee-Plaintiff*.	January 17, 2019 Court of Appeals Case No. 18A-PL-925 Appeal from the Henry Circuit Court The Honorable Kit C. Dean Crane, Judge Trial Court Cause No. 33C02-1703-PL-19

Mathias, Judge.

This case requires us to once again delve into what we have previously referred to as the "unfortunately convoluted and complex" and "Byzantine" Medicaid system. *Legacy Healthcare, Inc. v. Barnes & Thornburg*, 837 N.E.2d 619, 622 & n.2 (Ind. Ct. App. 2005), *trans. denied*; *see also Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (referring to the Social Security Act, of which the Medicaid system is a part, as having a

"Byzantine construction" that "makes the Act 'almost unintelligible to the uninitiated.' ") (quoting *Friedman v. Berger*, 547 F.2d 724, 727, n. 7 (2d Cir. 1976)).

At issue here is how to determine the portion of nursing home costs required to be paid by Lance Patterson ("Patterson"), a Medicaid recipient whose limited income is subject to a garnishment order due to a rather substantial child support arrearage. The Indiana Family and Social Services Administration ("the FSSA") determined that the garnished portion of Patterson's income should be included when determining Patterson's portion of the cost of his care. Patterson challenged this decision by filing a claim for judicial review in Henry Circuit Court. The trial court entered judgment in favor of Patterson, determining that the garnished portion of Patterson's income should be excluded when determining Patterson's share of nursing home costs because Patterson did not actually receive this income. The FSSA appeals the trial court's decision, arguing that the trial court erred in granting Patterson's petition because the FSSA's decision was consistent with federal and state law and was neither arbitrary nor capricious. Because we agree with the FSSA, we reverse.

The Medicaid System

A. Medicaid Overview

Before we address the specific facts of this case, we first present a relatively brief explanation of the Medicaid system. Title XIX of the Social Security Act,

referred to as "Medicaid," was enacted by the United States Congress in 1965. *Legacy Healthcare*, 837 N.E.2d at 622 (citing *Sullivan v. Day*, 681 N.E.2d 713, 715 (Ind. 1997)). The purpose of Medicaid "is to provide medical assistance to needy persons whose income and resources are insufficient to meet the expenses of health care." *Brown v. Ind. Family & Soc. Servs. Admin.*, 45 N.E.3d 1233, 1236 (Ind. Ct. App. 2015) (citing *Ind. Family & Soc. Servs. Admin. v. Thrush*, 690 N.E.2d 769, 771 (Ind. Ct. App. 1998), *trans. denied*).

"The Medicaid statutes create a comprehensive cooperative federal-state program for medical care under which participating states are federally financed for their medical assistance programs if they submit a state plan which comports with federal requirements." *Legacy Healthcare*, 837 N.E.2d at 622 (citing 81 C.J.S. *Social Security & Public Welfare* § 247 (2004)). Thus, the Medicaid program operates through a combined scheme of state and federal statutory and regulatory authority. *Brown*, 45 N.E.3d at 1236. Although a state's participation in Medicaid is voluntary, once a state chooses to participate, as Indiana has, that state must comply with the federal statutes and regulations governing the program. *Legacy Healthcare*, 837 N.E.2d at 622 (citing 81 C.J.S. at § 247); *see also Schweiker*, 453 U.S. at 43–44 (stating that states participating in Medicaid must "grant benefits to eligible persons 'taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary [of Health and Human Services],

available to the applicant.'") (citing 42 U.S.C. § 1396a(a)(17)(B)).

States that elect to participate in the Medicaid program and receive federal funds must make Medicaid available to all persons who are deemed "categorically needy." *Lazzell v. Ind. Family & Soc. Servs. Admin.*, 775 N.E.2d 1113, 1117 (Ind. Ct. App. 2002) (citing *Sullivan*, 681 N.E.2d at 715); *see also* 42 C.F.R. § 435.4 (defining "categorically needy."). Whether a person is "categorically needy" is determined by reference to eligibility for certain other programs, including supplemental security income ("SSI"). *See id.*; *see also* 42 U.S.C. § 1396a(a)(10)(A)(i)(II)(aa);[1] 42 C.F.R. § 435.120.

States may also opt to provide Medicaid available to the "optional categorically needy."[2] That is, states may, at their option, cover other categorically needy groups of people. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.201; *Herweg v. Ray*, 455 U.S. 265, 268–69

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[1] A citation as complex as section "1396a(a)(10)(A)(i)(II)(aa)" calls to mind Judge Friendly's comment that "a draftsman who has gotten himself into a position requiring anything like this should make a fresh start." *Friedman*, 547 F.2d at 727 n.7. We further agree that "[s]uch unintelligibility is doubly unfortunate in the case of a statute dealing with the rights of poor people." *Id.*

[2] States are permitted, but not required to offer Medicaid to those deemed "medically needy," which is defined as "individuals whose income or resources were too great to qualify for categorically needy assistance but were unable to pay for necessary medical expenses." *Lazzell*, 775 N.E.2d at 1117 (citing *Roloff v. Sullivan*, 975 F.2d 333, 335 (7th Cir. 1992)). Indiana has chosen not to provide Medicaid to the medically needy. *Id.*

(1982). Indiana has chosen to provide Medicaid coverage to certain institutionalized, disabled individuals whose monthly income is too high to otherwise qualify as categorically needy, so long as the individual's monthly income does not exceed the special income level of 300 percent of the maximum payable SSI benefit. *See* 405 I.A.C. 2-1.1-5(g); *see also* 42 U.S.C. § 1396a(a)(10)(A)(ii)(V); 42 C.F.R. § 435.1005.

B. Medicaid Eligibility Determination

States participating in Medicaid must establish reasonable standards for determining eligibility, including the reasonable evaluation of an applicant's income and resources. *Brown*, 45 N.E.3d at 1236. To qualify for Medicaid, an applicant must meet both an income-eligibility test and a resources-eligibility test. *Id.* If either the applicant's income or the value of the applicant's resources is too high, the applicant does not qualify for Medicaid. *Id.*

The federal Department of Health and Human Services ("HHS") has promulgated regulations establishing financial eligibility requirements for Medicaid applicants and recipients. A state may opt to use a less restrictive income methodology, so long as its methods do not result in granting Medicaid benefits to those whose income, as calculated using SSI standards, exceeds the "special income level." *See* 42 U.S.C. § 1382a; 42 U.S.C. § 1396a(r)(2); 42 C.F.R. § 435.601(d)(1)(ii), (d)(2). A state's plan must specify whether it will use the relevant federal standard or a less-restrictive

standard. 42 C.F.R. § 435.601(f). Indiana has adopted the federal rule, not a less-restrictive option. Specifically, 405 Indiana Administrative Code section 2-1.1-5(a) states, "Individuals declared eligible for benefits by reason of age, disability, or blindness are subject to the income definition and exclusions set forth in 42 U.S.C. 1382a and 20 CFR Part 416, Subpart K Income."[3]

A disabled person who has been continuously institutionalized for at least thirty days is eligible for Medicaid under federal standards if his or her monthly income, as determined under 42 U.S.C. § 1382a, does not exceed 300 percent of the maximum SSI benefit. 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(V), 42 C.F.R. §§ 435.236(a), 435.1005. In 2016, the maximum payable SSI benefit for an individual was $733 monthly in 2016. It increased to $735 in 2017, and to $750 in 2018. *See SSI Federal Payment Amounts* https://www.ssa.gov/oact/COLA/SSIamts.html.

An individual's includible income includes gross earnings, net rental income, net self-employment income, and all gross unearned income except SSI benefits. 405 I.A.C. 2-1.1-5(g)(2). In determining Medicaid eligibility, the Act requires the State to "tak[e] into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, *available* to the applicant or recipient[.]" 42 U.S.C. § 1396a(a)(17)(B) (emphasis added).

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[3] 20 C.F.R. Part 416, Subpart K encompasses 20 C.F.R. §§ 416.1100 through 416.1182.

Pursuant to 42 U.S.C. § 1382a(a), "income" includes "both earned income and unearned income[.]" "Earned income" includes wages, and "unearned income" including disability benefits. *Id.* at § 1382a(a)(1)(A), (a)(2)(B). As explained in the Code of Federal Regulations section entitled "What is earned income":

> Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. **We include more than you actually receive if amounts are withheld from earned income because of a garnishment** or to pay a debt or other legal obligation, or to make any other payments. . . .

20 C.F.R. § 416.1110 (emphasis added).

A similar provision applies to unearned income:

> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
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> * * *
>
> (2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.

20 C.F.R. § 416.1123(b)(2).

In the present case, neither party makes any argument regarding Patterson's Medicaid eligibility;

they both agree that Patterson is eligible for Medicaid. The question is, even though Patterson is eligible for Medicaid, how much of his income must he still contribute to the cost of his care, and how is this amount to be determined.

C. Post-Eligibility Income Determination

A disabled person who is in an institution and who qualifies for Medicaid must still contribute some of his or her income to the cost of his or her institutional care, and Medicaid pays for the remaining costs at the Medicaid reimbursement rate. Medicaid Program Payments to Institutions, 53 Fed. Reg. 3586, 3586 (Feb. 8, 1988) (explaining 42 C.F.R. § 435.725). A state Medicaid agency must "reduce its payment to an institution . . . by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income." 42 C.F.R. § 435.725(a)(1). States have the option of using either the individual's "total income received" or a projected "monthly income for a prospective period not to exceed 6 months." 42 C.F.R. § 435.725(e)(1).

Once the agency identifies the recipient's total income, it must then apply the deductions in paragraphs (c) and may apply the items listed in paragraph (d). 42 C.F.R. § 435.725(c), (d). The five mandatory deductions are: (1) a personal-needs allowance; (2) maintenance needs of spouse; (3) maintenance needs of family; (4) qualified medical expenses not subject to third-party payment; and (5) the full amount of SSI

benefits. 42 C.F.R. § 435.725(c).[4] The recipient's total income less these deductions constitutes his Medicaid liability—i.e., what he must pay for his nursing home care and what Medicaid will not cover. 42 C.F.R. § 435.725(a).

In Indiana, 405 I.A.C. 2-1.1-7(a) addresses the portion of costs that a Medicaid recipient, such as Patterson, must pay toward the costs of his or her care. The FSSA first determines the "recipient's total income that is not excluded by federal statute." 405 I.A.C. 2-1.1-7(a)(2). It then makes five deductions: (1) a statutory-minimum personal-needs allowance; (2) an increased personal-needs allowance; (3) an amount for health insurance premiums; (4) certain medical expenses for necessary or remedial care; and (5) federal, state, and local income taxes. 405 I.A.C. 2-1.1-7(a)(3)–(7). "The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced," and which must be covered by the Medicaid recipient. 405 I.A.C. 2-1.1-7(a). The parties refer to this as the recipient's "liability," i.e., the portion of the costs of care that must be borne by the recipient. It is this amount, and its calculation, that is at issue here.

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[4] A state agency may also deduct an amount for maintenance of the recipient's home, so long as there is a reasonable likelihood that the person will return home within six months. 42 C.F.R. § 435.725(d).

Facts and Procedural History

The historical facts underlying this case appear to be relatively undisputed. At the time of the trial court's decision, Patterson was sixty-two years old and a resident of Miller's Merry Manor nursing home ("Miller's") in Middletown, Indiana. Patterson resides in Miller's as a result of his chronic heart failure, diabetes, and various other medical issues.

Patterson's only income comes from a Social Security Disability Insurance ("SSDI") benefit of $1,236 per month. Patterson is unmarried but has a thirty-two-year-old daughter from a prior marriage. Due to his failure to pay child support during his daughter's minority, Patterson accumulated a large child support arrearage of more than $56,000 in Minnesota.[5] As a result of this arrearage, a Minnesota court issued a garnishment order. Pursuant to this garnishment order, the Social Security Administration ("the SSA") withholds $730.80 from each of Patterson's monthly SSDI checks. The SSA also deducts $2.60 from Patterson's benefit check for monthly health plan premiums. Thus, only $502.60 each month is actually deposited in Patterson's bank account.

The FSSA determined that Patterson was eligible for Medicaid in October 2016; Patterson's income level of $1,236 was less than the "special income level" of $2,199, which represented three times the 2016

[5] This amount represents the arrearage as of December 2016, when the trial court issued its order. The arrearage had been as high as $94,000 in 2011.

maximum payable Supplemental Security Income benefit of $733. The FSSA further determined that Patterson's liability for his nursing home care was $1,181. The FSSA determined Patterson's liability by subtracting from Patterson's total income a $52 personal-needs allowance and $2.60 for health care premiums. The FSSA did not take into consideration that only $502.60 each month was actually deposited in Patterson's bank account, as it considered the whole of Patterson's SSDI benefit as income, without deducting the $730.80 garnished from his check to pay toward the child support arrearage.

On November 1, 2016, the FSSA notified Patterson by mail that, as of that date, he would be responsible for paying $1,181 per month to his nursing home. Patterson administratively appealed the FSSA's determination, arguing that the $730.80 garnished for his child support arrearage should not have been included in determining his Medicaid liability. On December 16, 2016, an Administrative Law Judge ("ALJ") held a hearing on the issue. At the time of this hearing, Patterson owed the nursing home $8,890. On January 20, 2017, the ALJ affirmed the FSSA's initial determination. Patterson then appealed to the FSSA, which on March 2, 2017, issued a final agency action affirming the decision of the ALJ.

Patterson then sought judicial review of the FSSA's decision, filing a complaint for judicial review

on March 31, 2017.[6] The trial court held a hearing on February 21, 2018, and issued findings of fact and conclusions of law on March 21, 2018, reversing the FSSA's determination. The FSSA now appeals.

Standard of Review

The FSSA appeals from the trial court's grant of Patterson's complaint for judicial review of an agency decision. Pursuant to the Indiana Administrative Order and Procedures Act ("AOPA"), "[t]he burden of demonstrating the invalidity of agency action is on the party to the judicial review proceeding asserting invalidity." Ind. Code § 4-21.5-5-14(a). A court may set aside an agency action only if it is:

> (1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
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> (2) contrary to constitutional right, power, privilege, or immunity;
>
> (3) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
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> (4) without observance of procedure required by law; or
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> (5) unsupported by substantial evidence.

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[6] Patterson's complaint included counts for declaratory and injunctive relief under 42 U.S.C. section 1983. The parties later agreed to dismiss the section 1983 claims.

Id. at § 14(d). Patterson argued, and the trial court agreed, that the FSSA's income determination was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" under subsection 14(d)(1).

Both a trial court and an appellate court review the decision of an administrative agency with the same standard of review. *Gray v. Med. Licensing Bd. of Ind.*, 102 N.E.3d 917, 921 (Ind. Ct. App. 2018). When reviewing a challenge to an administrative agency's decision, a court may not re-try "the facts *de novo* nor substitute its own judgment for that of the agency." *Jay Classroom Teachers Association v. Jay School Corp.*, 55 N.E.3d 813, 816 (Ind. 2016). Instead, a court must defer to an agency's findings if they are supported by substantial evidence. *Id.*

In contrast to our deference to an agency's factual findings, it has been held that a court may review an agency's conclusions of law *de novo*. *Id.* But despite this "*de novo*" review, a court is to give "great weight" to the agency's interpretation of the law. *Id.* (citing *West v. Office of Ind. Sec'y of State*, 54 N.E.3d 349, 353 (Ind. 2016)). "In fact, 'if the agency's interpretation is reasonable, we stop our analysis and need not move forward with any other proposed interpretation.'" *Id.* This is true even if the opposing party presents an equally reasonable interpretation. *Id.*

Patterson argues that our usual deference to an agency's interpretation should not apply because the FSSA is interpreting a federal regulation. Patterson also notes that our supreme court has cited with

approval the proposition that "'[c]ourts will give no special deference to interpretation by one agency of another agency's rules.'" *LTV Steel Co. v. Griffin*, 730 N.E.2d 1251, 1257 (Ind. 2000) (quoting Charles H. Koch, Jr., *Administrative Law and Practice* § 11.26, at 140 (2d ed. 1997)). But the two agencies at issue in *LTV Steel* were two separate state-level agencies: the State Ethics Commission and the Indiana Board of Safety Review. The *LTV Steel* court held that the Board of Safety Review's interpretation and enforcement of the State Ethics Code was in excess of the Board's jurisdiction. *Id.* at 1258.

In contrast, the Medicaid program is, as discussed above, a cooperative federal-state program. And Indiana is required to comply with the federal statutes and regulations governing the program. *Legacy Healthcare*, 837 N.E.2d at 622. Thus, we will give great weight to the FSSA's interpretation of federal Medicaid statutes, rules, and regulations. *See Assateague Coastkeeper v. Maryland Dep't of Env't*, 28 A.3d 178, 206 (2011) (holding that when a state agency is charged with the day-to-day responsibility for enforcing and administering a federal regulation, courts should give deference to the agency's interpretation of that regulation if the language of the agency's regulation is unclear and susceptible to different reasonable interpretations and the agency's interpretation of the regulation is reasonable) (citing *In re Cities of Annandale & Maple Lake NPDES/SDS Permit Issuance for the Discharge of Treated Wastewater*, 731 N.W.2d 502, 515 (Minn. 2007). Accordingly, we will defer to the

FSSA's factual findings and only determine if its interpretation of the Medicaid statutes and regulations are reasonable.

Discussion and Decision

As noted above, the parties do not dispute that Patterson is eligible for Medicaid; both agree that he is. Patterson also does not deny that, when determining eligibility for Medicaid, the FSSA is required to include all of his income, including the portion thereof subject to garnishment. Instead, Patterson notes that there are two, discrete income calculations at issue here. The first one is used in determining Medicaid eligibility; the second, post-eligibility determination is used in determining the Medicaid recipient's liability for a portion of his or her care.

In this post-eligibility determination, the FSSA argues that Patterson's income is still calculated to include even that portion of his income that is subject to the garnishment order. Patterson claims that, even though the garnished portion of his income is included when determining his eligibility for Medicaid, it is to be excluded when determining his liability for his care. Thus, the question before us is how to calculate Patterson's income for the purposes of determining the portion of his health care expenses Patterson is required to pay himself.

The applicable FSSA regulation, entitled "Post-eligibility treatment of income," provides in relevant part as follows:

This subsection applies to individuals in institutions.

(1) Except as provided in 405 IAC 2-3-17, the following procedure shall be used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under section 5(g) of this rule and who is residing in an institution as defined in 405 IAC 2-1-1(e).

(2) Determine the applicant's or recipient's **total income that is not excluded by federal statute**, which includes amounts deducted in the eligibility determination under section 5(g)(3) of this rule.[7]

(3) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.

(4) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or recipient's legal guardian, not to exceed thirty-five dollars

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[7] 405 I.A.C. section 2-1.1-5(g)(3) provides that "[a]ny income from another financially responsible relative described under 405 IAC 2-3-4 will not be included when determining whether an individual falls below the special income level." There is no indication that Patterson has "another financially responsible relative."

> ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney's fees for which the guardian is liable.
>
> (5) Subtract the amount of any health insurance premiums.
>
> (6) Subtract an amount for expenses incurred for necessary or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.
>
> (7) Subtract an amount for federal, state, and local taxes owed and paid by the applicant or recipient. This deduction is limited to one (1) calendar month per year.
>
> The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

405 I.A.C. § 2.1.1-7(a). Notably, there is no provision for the subtraction of wages that are subject to garnishment.

The federal regulation regarding the post-eligibility determination of income is 42 C.F.R. § 435.725. This rule, entitled "Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care," provides in relevant part as follows:

(a) Basic rules.

(1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, **from the individual's total income**,

(2) **The individual's income must be determined in accordance with paragraph (e) of this section.**

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) Applicability. This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) Required deductions. In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. **Income that was disregarded in determining eligibility must be considered in this process.**

(1) Personal needs allowance. A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

* * *

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) Maintenance needs of spouse. . . .

* * *

(3) Maintenance needs of family. . . .

* * *

(4) Expenses not subject to third party payment. Amounts for incurred expenses

for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) Continued SSI and SSP benefits. The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1)(E) and (G) of the Act.

(d) Optional deduction: Allowance for home maintenance. . . .

* * *

(e) Determination of income—

(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, **the agency may use total income received**, or it may project monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to

exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses—

(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

42 C.F.R. § 435.725 (emphases added).

The FSSA contends that the amount of the costs of medical care that Patterson is required to pay—his liability—is determined as set forth in subsection (a) of 42 C.F.R. section 435.725. That is, the FSSA must

reduce its payment to the nursing home "by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of [section 435.725] from [Patterson]'s **total income**." *Id.* at § 435.725(a) (emphasis added). The FSSA argues that Patterson's total income includes the amount subject to the Minnesota court's garnishment order. Otherwise, the FSSA argues, Medicaid would effectively be subsidizing Patterson's child support delinquency.

Patterson argues that that portion of his income that is subject to garnishment should not be counted toward his income because subsection (e) refers to "total income **received**." *Id.* at § 435.725(e). Patterson argues that he does not "receive" that portion of his income that is subject to the garnishment order, and that this amount should therefore not be included when determining his income for purpose of calculating his liability for his medical care.

We agree that the references to "total income" in subsection 435.725(a) and "total income received" in subsection 435.725(e) render this section ambiguous. That is, they are subject to two different, reasonable interpretations: one includes all income, the other only income that is "received." But this is all the more reason for us to defer to the FSSA's interpretation of this rule.

More importantly, the HHS has indicated that it interprets the income calculation set forth in 42 C.F.R. section 435.725 to include the same income calculation that is used in determining Medicaid eligibility, which

calculation includes income that is subject to garnishment. When issuing an amendment to 42 C.F.R. section 435, the HHS Secretary commented that, regarding the issue of interest and dividends, "[t]he post-eligibility process is based on a consideration of all income considered in the eligibility process." Medicaid Program Payments to Institutions, 53 Fed. Reg. 3586, 3587 (Feb. 8, 1988).

Thus, the HHS has determined that the post-eligibility income calculation for determining a recipient's liability includes "all income" considered in the initial eligibility determination.[8] And it is abundantly clear that the initial eligibility income calculation includes income subject to garnishment. *See* 20 C.F.R. § 416.1110; Supplemental Security Income for the Aged, Blind, and Disabled; How We Count Earned and Unearned Income; Funds Used to Pay Indebtedness, 56 Fed. Reg. 3209 (Jan. 29, 1991) ("These final rules clarify the regulations to reflect a longstanding Social Security Administration (SSA) policy that amounts withheld from earned and unearned income for payment of a debt or other legal obligation are included in income for the purpose of determining eligibility and payment amount under the Supplemental Security Income (SSI) program."). This is directly contrary to Patterson's position that income should be calculated

[8] In fact, 42 C.F.R. section 435.725(c) provides that, in the post-eligibility income determination, "[i]ncome that was disregarded in determining eligibility must be considered in this [post-eligibility] process." Accordingly, the post-eligibility determination is, if anything, more inclusive of income than the eligibility determination.

differently depending upon whether the agency is determining eligibility or post-eligibility recipient liability.

Moreover, the FSSA's interpretation is not unreasonable because it acknowledges that Patterson still receives the benefit of the money that is garnished. By having the garnishment applied to his outstanding child support arrearage, Patterson has received a benefit from the garnishment—his debt is reduced. In fact, if we were to agree with Patterson, the result would be that Medicaid would be effectively subsidizing his child support arrearage. This can hardly have been the intent of the Medicaid program. *See Peura ex rel. Herman v. Mala*, 977 F.2d 484, 490 (9th Cir. 1992) (noting that excluding the full amount of a child support obligation from the "available" income of a Medicaid recipient would lead to unintended subsidization of a disproportionate amount of health care benefits); *Cervantez v. Sullivan*, 963 F.2d 229, 235 (9th Cir. 1992) (noting that excluding garnishment from calculation of income would give claimants an incentive to fail to pay their debts and await garnishment, thereby shifting the cost of repayment to the SSI program), *as amended on denial of reh'g*; *see also* 56 Fed. Reg. 3209, 3211 ("It is not the purpose of the SSI program to subsidize any types of indebtedness whether that indebtedness results from a debtor/creditor relationship or from an obligation imposed by public policy.").

In short, the FSSA's interpretation of the applicable statutes and regulations is reasonable. Because the FSSA's interpretation of the regulations is reasonable,

"we must stop our analysis and need not move forward with any other proposed interpretation." *Jay Classroom Teachers Ass'n*, 55 N.E.3d at 816 (citing *West*, 54 N.E.3d at 353). Accordingly, the trial court erred in determining that the FSSA's interpretation was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

We find support for our conclusion in *Ussery v. Kansas Department of Social & Rehabilitation Services.*, 899 P.2d 461 (Kan. 1995). In that case, as here, there was no question that Ussery was entitled to Medicaid benefits. Rather, the issue was the extent of his "patient liability," i.e., "the amount that the individual is required to pay towards the cost of care which the individual receives in an institutional arrangement." *Id.* at 464. Ussery argued that his court-ordered support for his ex-wife should be excluded from his income when determining his liability. Because neither federal nor state regulations contained an exemption for such support payments, the court rejected Ussery's contention and held that the Kansas Medicaid agency's calculation, which included his support payment, was part of Ussery's available income. *Id.* at 466–67.

A similar conclusion was reached in *Tarin v. Commissioner of the Division of Medical Assistance*, 678 N.E.2d 146 (Mass. 1997). The state Medicaid agency determined that Tarin's court-ordered child support payments should be included in his available income when determining his patient liability. On appeal, the court affirmed the agency's determination, noting that the regulations concerning income exemptions for

Medicaid recipients do not provide for any exemption for child support payments when the recipient is not living with a spouse. 678 N.E.2d at 151. The court concluded that the HHS Secretary "has made it clear that income 'available' to a divorced Medicaid recipient may include income used to make court-ordered child support payments." *Id.* The court also noted that:

> Three United States Circuit Courts of Appeals that have considered the matter all have upheld the disallowance of deductions for court-ordered child support payments for a Medicaid income availability determination. *See Himes v. Shalala*, [999 F.2d 684, 690–691 (2d Cir.1993)] (inclusion of child support payments in "available" income is "reasonable attempt to interpret and apply all sections of the statute"; Secretary's interpretation "is not at odds with the plain meaning of the statute, is reasonable, and should therefore be accorded the usual deference"); *Peura v. Mala*, 977 F.2d 484, 491 (9th Cir. 1992) ("high degree of deference" is owed to Secretary's determination); *Emerson v. Steffen*, [959 F.2d 119, 123 (8th Cir. 1992)] ("[a]lthough not directly defining the term 'available,' the regulations make it plain that . . . states do not have to exclude [child support] payments from income when determining Medicaid eligibility. . . .").

Tarin, 678 N.E.2d at 152.[9]

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[9] Patterson argues that the cases cited by the *Tarin* court, and by the FSSA in the present case, dealt with determining income for the purposes of Medicaid eligibility only, not for

Patterson relies heavily on *Mulder v. South Dakota Department of Social Services.*, 675 N.W.2d 212 (S.D. 2004). In *Mulder*, the South Dakota Medicaid agency determined that Mulder was eligible for Medicaid, but when determining his liability for his care, the agency did not exclude from his monthly income $180 that was withdrawn to pay his alimony obligation. Mulder appealed, and a three-justice majority of the South Dakota Supreme Court agreed with him that the alimony should not be included in his income. *See id.* at 217 ("[T]he Department's determination that Mulder's alimony payments constitute "available income" was not reasonable). We simply disagree with the *Mulder* court and decline to follow it.

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post-eligibility patient liability purposes. The *Tarin* court rejected a similar argument, stating:

> We recognize that in both *Himes* and *Emerson* the courts were reviewing the Secretary's determination of a recipient's "available" income for the purpose of establishing only eligibility for Medicaid, and not benefit levels, the issue in this case. However, in *Peura*, the plaintiff, like Tarin, challenged a State's determination of required payments for nursing home costs. In upholding the Secretary's determination, the United States Court of Appeals for the Ninth Circuit concluded that it was "of little import" that the Secretary's determination regarding Peura's child support obligations came "in the context of a post-eligibility determination." *Peura*, *supra* at 487 n.4. *See Ussery v. Kansas Dep't of Social & Rehabilitation Servs*., 258 Kan. 187, 899 P.2d 461 (1995), upholding the inclusion of court-ordered spousal support payments in a Medicaid recipient's "available" income in establishing benefit levels.

678 N.E.2d at 153. As discussed above, we agree with the *Tarin* court's reasoning on this matter.

Patterson makes a sound policy argument that the FSSA's decision leaves him in the lurch. That is, even though he qualifies for Medicaid, the FSSA's inclusion of the garnished portion of his income in determining his liability means that he is stuck owing the nursing home more money than he has access to. This means that either the nursing home must continue to care for him at a loss, or he must come up with another source of income, which is unlikely. Hopefully, Patterson can find care at a less expensive facility, or at least one that is willing to accept that portion of his care that Medicaid is willing to pay for.

Despite the merits of Patterson's argument, it is not the role of this court to determine Medicaid policy. That role belongs to the FSSA and the HHS. The only question before us is whether the FSSA's interpretation of the relevant state and federal regulations is reasonable, and we cannot say that the FSSA's interpretation is unreasonable.

Conclusion

Because the FSSA is responsible for implementing the cooperative state-federal Medicaid system in Indiana, we give its interpretation of these statutes and regulations great weight. And since the FSSA's interpretation is reasonable, our analysis stops there. The trial court's analysis should have stopped there too. We therefore reverse the judgment of the trial court.

Reversed.

Bailey, J., concurs with opinion.

Bradford, J., concurs.

IN THE
COURT OF APPEALS OF INDIANA

Indiana Family and Social Services Administration, *Appellant-Defendant*, v. Lance Patterson, *Appellee-Plaintiff*.	Court of Appeals Case No. 18A-PL-925

Bailey, Judge, concurring.

I agree that the trial court erred, although I do so reluctantly. "Medicaid is a cooperative State and Federal program designed to provide health care *to needy individuals*." *Mulder v. South Dakota Dept. of Social Serv.*, 675 N.W.2d 212, 214 (S.D. 2004) (emphasis added). Patterson is, without dispute, a needy individual based upon his limited resources and his institutionalized status. Yet, the FSSA position would leave him evicted from his care facility or necessitate that the facility continuously and substantially subsidize Patterson – something not uniformly required of other providers participating in the Medicaid program. At the end of the process (whereby eligibility is determined in step one and financial liability is calculated in step two), payment allocation is to be made between

government funding and what the impoverished individual can afford to pay. There is no onus upon a provider to subsidize the patient beyond the provision of services at an already-discounted rate.

Unearned income, such as Patterson's disability payments, may include garnished sums. 20 C.F.R. § 416.1123(b)(2). Patterson meets eligibility requirements even with garnished sums, and step two, the financial liability calculation, incorporates the garnished sums as part of Patterson's income. As for Patterson's ability to pay, however, he simply does not have access to funds to satisfy the liability assigned to him. Given the humanitarian purposes of Medicaid, I would expect that "received" should be understood with reference to what one has with which to pay and not a factual or legal fiction. Nevertheless, the establishment of public policy is a legislative function. There are certainly competing policies here: we require parents to support their children, we do not insist that private enterprise subsidize an individual's non-payment, and we do not abandon desperately ill and destitute individuals without care.

True, Patterson did not pay his child support in full. He should have done so if able, given his chronic health conditions. Yet Medicaid is not restricted to those who have acted only legally and wisely. It is plain to me that unwise choices may lead to or contribute to impoverishment (for example, substance abuse, incarceration, or leaving employment). But ultimately, Medicaid applicants are not categorically excluded for past lifestyle choices. Nor are they uniformly penalized for

having dependents. Indeed, familial obligations are taken into account in similar contexts. 42 U.S.C. § 435.725 permits a spousal allowance and a family allowance for certain dependent family members living in the home.

I do not condone a voluntary decision not to pay child support. Yet I find it ironic that, were Patterson imprisoned for felony non-support, he would be provided with the care he desperately needs. In the convergence of circumstances present here – total disability requiring institutionalization, impoverishment, and a state-enforced action for child support arrearage – there is no optimal outcome with equity for all concerned. I understand the trial court's attempt to exercise compassion. However, because the trial court found invalidity of agency action where there was none, I concur in the reversal.

STATE OF INDIANA	)	IN THE HENRY
COUNTY OF HENRY	)	CIRCUIT COURT 2
LANCE PATTERSON	)	CASE NO: 33C02-1703-PL-000019
V.	)	
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT ENTRY ON PLAINTIFF'S REQUEST FOR JUDICIAL REVIEW

(Filed Mar. 21, 2018)

FINDINGS OF FACT

1. Plaintiff Lance Patterson ("Mr. Patterson") is now 62 years of age. At the time of the administrative hearing and when this case was filed, he was a resident of Miller's Merry Manor, a nursing home located in Middletown, Henry County, Indiana.

2. Defendant Indiana Family and Social Services Administration ("FSSA") is the state agency which administers Medicaid in Indiana.

3. Mr. Patterson is a recipient of the Medicaid category known as Medical Assistance to the Disabled. ALJ Decision, Findings of Fact ¶1, Rec. p. 148.

4. Mr. Patterson's only income is Social Security Disability benefits. In 2016 his gross monthly benefit was $1,236 per month. ALJ Decision, Findings of Fact ¶15, Rec. p. 149.

5. From Mr. Patterson's gross monthly benefits, the Social Security Administration (SSA) withheld $730.80 per month for child support and $2.60 for a health plan premium, so that his net benefit payment was $502.60 per month. Rec., p. 105. The $730.80 is withheld pursuant to an Income Withholding for Support order issued by the Ramsey County Child Support and Collections office in Minnesota. The $730.80 order was all for past due support for child Tanisha Smith, born January 10, 1986. ALJ Decision, Findings of Fact ¶14, Rec. pp. 148-149, Appellant's Exh. 5, Rec. pp. 137 - 142.

6. On October 25, 2016 FSSA notified Mr. Patterson that beginning November 1, 2016 he was responsible for paying $1,181 monthly to the facility where he resides. FSSA refers to this amount as a "liability." ALJ Decision, Findings of Fact ¶3, Rec. p. 148; FSSA Notice, Rec. p. 3.

7. FSSA's budget sheet showed that Mr. Patterson's income of $1,236 was less than the "Special Income Level" of $2,199, so that he passed the eligibility step. Rec., p. 102.

8. FSSA's "Post – Eligibility Determination" budget shows that FSSA calculated Mr. Patterson's liability as follows:

Total Countable Income	$1,236.00
- Personal Needs Allowance	$ 52.00
- Health Plan Premium	$ 2.60
Mr. Patterson's Liability	$1,181.00

Rec., p. 102; ALJ Decision, Findings of Fact ¶16, Rec. p. 149 [This Finding contains a typing error listing Mr. Patterson's Social Security income as $1,126 rather than as $1,236].

9. In calculating the liability that Mr. Patterson was to pay to the nursing home each month, FSSA deducted the $2.60 that was deducted from his Social Security benefits for a health plan premium but did not deduct the $730.80 that was withheld for child support, with the result that his liability of $1,181 was $678.40 more than the net income of $502.60 which he actually received.

10. As of December, 2016, Mr. Patterson owed Miller's Merry Manor $8,890 due to his inability to pay his monthly liability. Appellant's Exh. 2, Rec. p. 116.

11. On November 23, 2016 Mr. Patterson submitted a request to FSSA to appeal the calculation of the liability he was to pay to the nursing home where he resided. ALJ Decision, Findings of Fact ¶4, Rec. p. 148.

12. A hearing on Mr. Patterson's appeal was conducted by FSSA Administrative Law Judge Rebecca Licht on December 16, 2016. Transcript of Hearing, Rec. pp. 18-88.

13. On January 20, 2016, the Administrative Law Judge issued a decision affirming FSSA's liability determination. ALJ Decision, Rec. pp. 146-154. In response to Mr. Patterson's position that the amount being deducted from his income pursuant to the child

support income withholding order should be deducted in determining his liability, the ALJ concluded:

> State Agency followed all regulations cited above to determine allowable deductions to be given to the Appellant when determining his monthly liability obligation. No regulation was found for garnishment of arrears child support to a non-dependent child to be an allowable deduction in liability amount determination.

ALJ Decision, Conclusions of Law, Rec. pp. 152-153

14. On February 3, 2017 Mr. Patterson, by his attorney, filed a request for agency review of the ALJ's decision. Rec. pp. 156-163.

15. On March 2, 2017 FSSA issued its Notice of Final Agency Action affirming the decision of the ALJ. Rec. p. 165.

16. Mr. Patterson filed his Verified Complaint for Judicial Review and Declaratory and Injunctive Relief on March 31, 2017.

CONCLUSIONS OF LAW

1. This Court has jurisdiction over Mr. Patterson's claim for judicial review under Ind. Code § 4-21.5-5.

2. The burden of demonstrating the invalidity of agency action is on Mr. Patterson, as he is the party

asserting the invalidity of the agency action. I.C. § 4-21.5-5-14(a).

3. In a judicial review proceeding, the court gives deference to the agency's findings of fact, if supported by substantial evidence, but the court determines questions of law.

4. Whether child support which is being garnished from Social Security benefits must be deducted when determining the liability which a Medicaid recipient must pay to a nursing home is a question of law for the court to decide.

5. Medicaid is a joint program between the federal and state government. Medicaid is established in federal law at Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* Medicaid is codified in Indiana at I.C. 12-15.

6. Both federal and state law refer to a two-step process for considering income for Medicaid nursing home residents. First, the agency makes an eligibility determination whether the person qualifies for Medicaid. It uses a budget it calls an "eligibility budget" to decide eligibility. An applicant or recipient must have countable income of no more than the "Special Income Level" to be eligible. 405 I.A.C. 2-1.1-5(g); 42 CFR §§ 425.236, 435.1005.

7. Second, once eligible, a new budget referred to as a "post eligibility" budget is used to calculate the liability. This is referred to as a "post eligibility determination." 405 I.A.C. 2-1.1-7(a); 42 CFR § 435.725.

8. Both the federal and the state regulations refer to using Supplemental Security Income (SSI) rules set forth in 42 U.S.C. § 1382a and 20 CFR Part 416 in the Medicaid eligibility determination. 405 I.A.C. 2-1.15(a); 42 CFR § 435.1005.

9. SSI rules provides [sic] that amounts payable for child support are not deductible when counting income for SSI eligibility. 20 CFR § 416.1132(b)(2).

10. Federal and state law require that child support that is being garnished be counted when determining eligibility for Medicaid.

11. Mr. Patterson passes the eligibility budget even though the child support being garnished is counted. Rec. p. 102 shows that Mr. Patterson passes the eligibility step because his gross income of $1,236 was less than the Special Income Level of $2,199.

12. Once an applicant or recipient passes the eligibility test, a separate budget known as a "post eligibility" budget is used to determine the liability the recipient is to pay to the nursing home.

13. Both the federal agency and FSSA have a separate regulation on post eligibility calculation of a liability. The federal regulation on post eligibility budgeting, 42 CFR § 435.725(e), repeatedly uses the phrase "income received." There is no cross reference in this regulation to the SSI rules.

14. 405 I.A.C. 2-1.1-7, which is FSSA's regulation concerning the post-eligibility treatment of income, does not refer to the SSI rules, but instead begins with

"the applicant's or recipient's total income that is not excluded by federal statute."

15. FSSA is subject not only to the federal Medicaid statute, but also to the federal Medicaid regulations. Since 42 CFR § 435.725(e) requires that the liability be based on the income received, when calculating a recipient's liability FSSA cannot count as income amounts which are being garnished from Social Security for the payment of child support and are thus not received.

16. Because a resident is only allowed to keep $52 per month as a personal needs allowance, it is unreasonable and arbitrary for FSSA to count the $730.80 which is being garnished from Mr. Patterson's income and to which he has no access when determining his liability. Counting the $730.80 results in Mr. Patterson not being able to pay his liability and results in Miller's Merry Manor receiving $730.80 a month less than its monthly bill for services.

17. Counting the amount being garnished for child support is contrary to 42 U.S.C. § 1396a(a)(17), which requires that a state's Medicaid plan must include reasonable standards and only consider income that is available.

18. FSSA's decision to count the $730.80 which is being garnished from Mr. Patterson's income was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. Mr. Patterson was prejudiced by FSSA's decision and is entitled to relief.

JUDGMENT

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that the decision by Defendant Indiana Family and Social Services Administration to count the $730.80 which was being garnished from Plaintiff Lance Patterson's Social Security benefits when determining the liability he was to pay to the nursing home is reversed. Plaintiff's judicial review claim is remanded to the Defendant Indiana Family and Social Services Administration for further proceedings consistent with this decision.

So ordered on this the 21st day of March, 2018.

/s/ Kit C. Dean Crane
Kit C. Dean Crane, Judge
Henry Circuit Court 2

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MAR 02 2017 Indianapolis, IN 46204-2739
317-234-3488
Toll Free: 866-259-3573
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IN THE MATTER OF:

CASE NAME: LANCE PATTERSON
CASE NUMBER: MD-48-1044100178 / 4000610561
HEARING DECISION RELEASE DATE:
January 20, 2017

NOTICE OF FINAL AGENCY ACTION

The record of the administrative hearing and the Administrative Law Judge's Findings of Fact and Decision in the above identified case were reviewed by the Secretary of the Family and Social Services Administration or their designee, and the agency hereby issues the following final order:

The Decision of the Administrative Law Judge dated **January 20, 2017 is affirmed**

This is the final action that the agency will be taking on this case. NO further consideration of this matter will be available through the Family and Social Services Administration.

However, if you have been the appellant in this matter, and are dissatisfied with this final agency action, you may ask that a court review the matter. This is a

process called judicial review. **If you choose to file a petition for judicial review, it must be filed within thirty-three (33) days after the date on this notice.** Since this involves filing a legal petition with the appropriate court, as well as other specific requirements, it is advisable (but not required) to have legal representation or help. However, FSSA **cannot** provide or pay for this representation, nor can the agency assist beyond the general information provided here. More detailed information on this process can be found in Indiana law at I.C.4-21.5-5.

cc:	CERT. MAIL #
LANCE PATTERSON	7015 0640 0003 2680 9908
DENNIS FRICK, ATTORNEY	7015 0640 0003 2680 9915
CHRISSY CALVERT	7015 0640 0003 2680 9922
MADISON COUNTY DFR	
GRANT SERVICE CENTER	
OMPP POLICY	
REBECCA LICHT, ADMINISTRATIVE LAW JUDGE	

NOTICE OF HEARING DECISION

(Filed Jan. 20, 2017)

APPELLANT:
Lance C. Patterson

CASE NUMBER:
1044100178/MAD/01/A04-4000610561

DATE OF NOTICE OF ACTION:
October 25, 2016

DATE OF APPEAL:
November 23, 2016

HEARING DATE:
December 16, 2016

PLACE: Madison County Office-DFR

JURISDICTION

This hearing was held under the provisions of 42 CFR 431.200 et seq. and 405 IAC 1.1-1 et seq.

ISSUE

The sole issue before the Administrative Law Judge is the amount of the Appellant's nursing facility liability.

The Administrative Law Judge has carefully reviewed the testimony presented at the hearing, all evidence, Federal/State regulations, and policy transmittals in regard to this matter. The Decision, which follows, outlines the facts and conclusions therefrom that are the basis for the final determination by the Administrative Law Judge.

THIS DECISION IS FAVORABLE TO THE STATE.

FINDINGS OF FACT

1. The Appellant is a recipient of Medical Assistance to the Disabled.
2. The Appellant, a single individual, resides in a nursing facility.
3. The State mailed notification to the Appellant on October 25, 2016 that his liability amount would be $1,181.00 effective November 1, 2016 for the reasons: "Income deduction allowed for new or increased health insurance premiums resulting in lower patient liability."
4. On November 23, 2016, the Office of Hearings and Appeals, Family and Social Services Administration, received an appeal request in the matter.
5. The hearing was held on December 16, 2016 under the provisions of 405 IAC 1.1-1 et seq. and 42 CFR 43,200 et seq.
6. State Agency provided case file materials for the hearing.
7. Appellant was accompanied and represented by Dennis K. Frick, Attorney with Indiana Legal Services, Inc.
8. Mr. Frick provided additional documents at the hearing.
9. Administrative Law Judge submitted Exhibits I through IV into record without objection by the State Agency.

10. Attorney for Appellant, Dennis Frick, requested a continuance to provide additional documents.

11. Administrative Law Judge granted a twenty-nine (29) day continuance without reconvening with no objection by the State Agency.

12. Additional documents were submitted on December 20, 2016 to Office of Hearings and Appeals as additional evidence to be entered into record for the Appellant.

13. Dennis Frick is appealing the liability amount determined for the Appellant does not include a deduction of $730.80 monthly garnished from his Social Security benefits with the check amount for $502.00.

14. The Appellant had arrears child support of $730.80 order effective July 9, 2012 in the state of Minnesota to be garnished from his Social Security benefits monthly and paid to Ramsey County Child Support and Collections with Doc ID: 123CS530002128 for Tanisha E. Smith born January 10, 1986 until further notice. Appellant's current balance remaining as of December 19, 2016 was $56,573.58.

15. The Appellant's income consists of $1,236.00 in gross Social Security benefits.

16. The Appellant has monthly expenses of $52.00 (personal needs) + $2.60 (health insurance premium) = $54.60. $1,126.00 (Social Security) – ($54.60) = $1,181.00 liability amount.

17. Appellant's Attorney contends the Appellant falls short of having the financial means to pay the

liability amount imposed by the State Agency when he does not have the access to the income. Examples provided for consideration were not current and exact situation as the Appellant's by Mr. Frick.

18. The Appellant's child, Tanisha E. Smith, is not a dependent under the age of twenty-one (21) residing in his home at the time he entered the nursing home setting or he claims for tax filing purpose. Thus, she is not considered as eligible dependent for any benefits from his income to be deducted for her.

LEGAL BASIS

405 IAC 2-1-1(e) "Institution" means a Title XIX certified hospital, nursing facility, intermediate care facility for the mentally retarded, or public institution. It does not include a facility where FFP is not available under 42 CFR § 435.1009.

405 IAC 2-1.11(j) "Special income level" refers to an amount equal to three hundred percent (300%) of the maximum benefit payable under the SSI program.

405 IAC 2-1.1-5(g) Individuals in institutions and individuals receiving home and community-based waiver services. To be considered income eligible while either residing in an institution or while receiving home and community-based waiver services, an individual must have countable income that is not more than the special income level.

(1) If residing in an institution, the individual must reside there for a period of not less than thirty (30) continuous days. If a person dies before the thirty (30) continuous days has passed, it is assumed that the thirty (30) continuous days has been met.

(2) The countable income for an individual described in this subsection consists only of income of the individual, which includes the following:

(A) Gross earnings.

(B) Net rental income.

(C) Net self-employment income.

(D) All gross unearned income, excluding SSI.

(3) Any income from another financially responsible relative described under 405 IAC 2-3-4 will not be included when determining whether an individual falls below the special income level.

(4) Income that has been placed or delivered to a trust described in 405 IAC 2-322(i)(2) will be disregarded for purposes of determining income eligibility under the special income level.

405 IAC 2-3-4, The countable income of an applicant for or recipient includes income of certain legally responsible relatives in the following situations:

(1) Except as provided in subdivision (3), if the applicant or recipient is under eighteen (18) years of age and is living with his or her parent(s), his or her income includes the income of his or her parent(s).

(2) If the applicant or recipient is living with his or her spouse, his or her income includes the income of his or her spouse.

(3) income of the parent(s) is not included if the applicant or recipient is under eighteen (18) years of age and has been approved from home and community based services under an approved waiver, in accordance with 42 USC § 1396n, which specifies the exclusion of parental income.

405 IAC 2-3-22(i) This section shall not apply to any of the following trusts:

(2) A qualified income trust composed only of:

(A) pension;

(B) Social Security;

(C) other income of the individual; and

(D) accumulated income in the trust;

where income of clauses (A) through (C) is delivered to the trustee of the trust, and the trust instrument provides that the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. The trust cannot be allowed to terminate in any manner at any time before the death of the individual.

405 IAC 2-1.1-7(a) This subsection applies to individuals in institutions.

(1) Except as provided in 405 IAC 2-3-17, the following procedure shall be used to determine the

amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under section 5(g) of this rule and who is residing in a Title XIX certified hospital, nursing facility, intermediate care facility for the mentally retarded, or public institution.

(2) Determine the applicant or recipient's total income that is not excluded by federal statute, which includes amounts deducted in the eligibility determination under section 5(g)(3) of this rule.

(3) Subtract the minimum personal needs amount that is equal to the special income level.

(4) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or recipient's legal guardian, not to exceed thirty-five dollars ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney's fees for which the guardian is liable.

(5) Subtract the amount of any health insurance premiums.

(6) Subtract an amount for expenses incurred for necessary or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.

(7) Subtract an amount for federal, state, and local taxes owed and paid by the applicant or recipient.

This deduction is limited to one (1) calendar month per year.

The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

(c) A child under eighteen (18) years of age determined eligible for benefits under section 5(g) of this rule will not have any resources or income from his or her parents deemed to such child under this section.

405 IAC 2-3-17(a) As used in this section, "institutionalized spouse" and "community spouse" have the meanings set forth in 42 USC §1396s-5(h)(1),

(b) The income eligibility of an institutionalized applicant or recipient with a community spouse shall be in accordance with 405 IAC 2-1.1-5(g).

(c) If an applicant or recipient is determined eligible for medical assistance under subsection (b), post-eligibility treatment of income to calculate the amount of income to be paid to the institution is determined as follows:

(1) Subtract from the applicant's or recipient's gross income determined according to ownership provisions set forth in 42 USC §1396r-5(b) those exclusions required by federal law.

(2) Subtract a spousal allocation equal to the community spouse's total income, in accordance with ownership provisions set forth in 42 USC

§1396r-5(b), subtracted from the sum of nine hundred eighty-four dollars ($984), plus an excess shelter allowance determined under 42 USC §1396r-5(d)(4), subject to all provisions of 42 USC §1396r-5(d), 42 USC §1396r-5(e), and 42 USC §1396r-5(g).

(3) Subtract an allocation for each dependent family member, as defined in subsection (e), equal to one-third (1/3) of the amount by which nine hundred eighty-four dollars ($984) exceeds the family member's total income, subject to the provisions of 42 USC §1396r-5(d), 42 USC §1396r-5(e), and 42 USC §1396r-5(g).

(d) The spousal allocation calculated in subsection (c)(4) *[sic]* is deducted from the institutionalized applicant's or recipient's income only to the extent that it is actually made available to, or for the benefit of, the community spouse.

(e) "Dependent family member", for the purpose of determining the allocation in subsection (c)(5) *[sic]*, is a person listed, as follows, who resides with the community spouse:

(1) Biological or adoptive children of either spouse under twenty-one (21) years of age.

(2) Biological or adoptive children of the community or institutionalized spouse who are:

(A) twenty-one (21) years of age or over; and

(B) claimed for tax purposes by either spouse under the Internal Revenue Service Code,

(3) The parent or parents of the community or institutionalized spouse who are claimed as dependents by either spouse for tax purposes under the Internal Revenue Service Code.

(4) Biological and adoptive siblings of the community or institutionalized spouse who are claimed by either spouse for tax purposes under the Internal Revenue Service Code.

IC 12-15-7-2 Fifty-two dollars ($52) monthly may be exempt from income eligibility consideration.

20 CFR § 416.1123(b)(2) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums as applied by 405 IAC 2-1.1-5(a).

405 IAC 2-1.1-5(a) Individuals declared eligible for benefits by reason of age, disability, or blindness are subject to the income definition and exclusions set forth in 42 U.S.C. 1382a and 20 CFR Part 416, Subpart K Income.

CONCLUSIONS OF LAW

Sole issue before Administrative Law Judge is whether the State Agency determined the Appellant's liability to nursing facility with allowable expenses provided from monthly gross income.

The State Agency added additional deduction of $2.60 for health premium which lowered the liability amount for the Appellant effective November 1, 2016.

The Appellant is responsible for a past debt of child support for a thirty-one year old child which effective in 2009 court ordered his obligation to pay. The garnishment of $730.80 has since been collected from his Social Security benefits.

State Agency followed all regulations cited above to determine allowable deductions to be given to the Appellant when determining his monthly liability obligation. No regulation was found for garnishment of arrears child support to a non-dependent child to be an allowable deduction in liability amount determination..

State Agency correctly determined the Appellant's monthly liability amount.

DECISION

The Administrative Law Judge sustains the determination of the monthly liability for Lance C. Patterson effective November 1, 2016.

/s/ Rebecca Licht
Rebecca Licht
Administrative Law Judge
(signature electronically affixed by Rebecca Licht, Administrative Law Judge)

[Appeal Rights Omitted]

In the
Indiana Supreme Court

Indiana Family & Social Services Administration, Appellant(s), v. Lance Patterson, Appellee(s).	Court of Appeals Case No. 18A-PL-00925 Trial Court Case No. 33C02-1703-PL-19

Order

(Filed May 9, 2019)

This matter has come before the Indiana Supreme Court on a petition to transfer jurisdiction, filed pursuant to Indiana Appellate Rules 56(B) and 57, following the issuance of a decision by the Court of Appeals. The Court has reviewed the decision of the Court of Appeals, and the submitted record on appeal, all briefs filed in the Court of Appeals, and all materials filed in connection with the request to transfer jurisdiction have been made available to the Court for review. Each participating member has had the opportunity to voice that Justice's views on the case in conference with the other Justices, and each participating member of the Court has voted on the petition.

Being duly advised, the Court DENIES the petition to transfer.

Done at Indianapolis, Indiana, on 5/9/2019.

/s/ Loretta H. Rush
Loretta H. Rush
Chief Justice of Indiana

All Justices concur, except David, J., and Goff, J., who vote to grant the petition to transfer.

42 C.F.R. § 435.725

§ 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.

(a) Basic rules.

(1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) Applicability. This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in

determining eligibility for SSI or optional State supplements.

(c) Required deductions. In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) Personal needs allowance. A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) Maintenance needs of spouse. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) Maintenance needs of family. For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) Continued SSI and SSP benefits. The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1)(E) and (G) of the Act.

(d) Optional deduction: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6–month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6–month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) Determination of income—

(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses—

(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section,

or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

History: [43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993; 58 FR 9120, Feb. 19, 1993; 58 FR 44457, Aug. 23, 1993; 59 FR 8138, Feb. 18, 1994]