State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
Post Office Box 1736
Romney, WV 26757

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

July 3, 2008

_____
By _____ POA
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held June 18, 2008. Your hearing request was based on the Department of Health and Human Resources' decision to terminate your Medicaid Aged Disabled Waiver case without evaluating your eligibility for Long Term Care Medicare coverage.

In arriving at a decision, the State Hearings Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

Eligibility for the Medicaid, Long Term Care Services is based on current policy and regulations. Some of these regulations state as follows: In no instance is Medicaid coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. (West Virginia Income Maintenance Manual § 2.4) .

The information, which was submitted at your hearing, revealed that your husband contacted the Department advising that you were entering a Nursing Home and your ADW case manager also contacted the Department regarding your entering the Nursing Home. Your niece made numerous unsuccessful inquires to the Department to obtain needed information about your Long Term Care Medicaid coverage.

It is the decision of the State Hearings Officer to **reverse** the actions of the Department to deny coverage through the Medicaid, Long Term Care Program for the months of September 2007 through January 2008.

Sincerely,

Sharon K. Yoho
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Ann Hubbard, I.M. Supervisor

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 08-BOR-1442**

West Virginia Department of Health and Human Resources,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on June 18, 2008 for _____. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on June 18, 2008 on a timely appeal, filed February 19, 2008.

II. PROGRAM PURPOSE:

The Program entitled Medicaid Long Term Care (nursing facility services) is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

Nursing Home Care is a medical service, which is covered by the State's Medicaid Program. Payment for care is made to nursing homes, which meet Title XIX standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

Claimants' Witnesses:
_____, Claimant's niece
_____, Business Office Manager, [redacted]

Department's Witnesses:
Ann Hubbard, I.M. Supervisor, DHHR

Presiding at the Hearing was Sharon K. Yoho, State Hearing Officer and a member of the State Board of Review.

IV. QUESTIONS TO BE DECIDED:

The question(s) to be decided is whether the Department was correct in denying financial ineligibility for the Medicaid, Long Term Care (Nursing Home) Program.

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual Chapter §1.2
West Virginia Income Maintenance Manual Chapter §2.4
West Virginia Income Maintenance Manual Chapter §17.1 , 17.3, 17.10
West Virginia Income Maintenance Manual Chapter §11.3

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:
D-1 Case Comments August 2, 2007 thru February 8, 2008
D-2 Banking Statement dated January 26, 2008
D-3 Notification of clients contribution toward cost of care dated February 12, 2008
D-4 Notice of denial of Nursing Home care coverage due to assets dated January 9, 2008

Claimant's Exhibits:
C-1 Banking statement dated September 10, 2007
C-2 Banking statement dated October 9, 2007

VII. FINDINGS OF FACT:

1) The claimant was an active recipient of the Aged Disabled Waiver, (ADW), program on August 6, 2007 when her husband notified the Department that he was scheduled for surgery and was to admit his wife into a nursing home in [redacted] until he is again able to care for her. An ADW case manager from [redacted] Home Health left a message on the Department's Nursing Home, (NH) worker's phone advising that she had an updated Pre Admission Screening, PAS for the claimant. The ADW program is a program for individuals who meet the eligibility requirements for Nursing Facility care but choose to remain in their home and receive in home services. The NH worker made an attempt on August 6, 2007 to return the call to [redacted] Home Health and left a message for the case manager to call her back. No additional contact was made between the Department and the Claimant's husband or case manager.

2) The claimant's representative testified that the Department closed the claimant's ADW case after hearing that the claimant had entered the nursing home.

3) On September 14, 2007, the Department received a call from the Nursing Home advising that the claimant had been discharged on September 11, 2007. On September 14, 2007, the NH worker made case comment in the file, "Closing Long Term Care in this case. Still open for QI-1 F". The case comments did not indicate that the claimant was again assessed for ADW services. Case comments did not show any documentation of a Long Term case ever being opened and the Nursing Home never received any payment for September. A denial notice was issued on January 9, 2008 stating that, "Your 9/11/07 application for Nursing Home Care Coverage has been denied. Reason: The amount of assets is more than is allowed for this benefit." This January notice also stated, "Your 9/11/07 application for SSI Related Medicaid for the Age, Blind and Disabled has been denied. Reason: Income is more than the net income limit for you to receive benefits. The amount of assets is more than is allowed for this benefit." The Department testified that the September denial for Nursing Facility care was in error due to the claimant's husband was alive and community spouse assets were to be considered.

4) The claimant's husband passed away on September 21, 2007 and the claimant was admitted back into Long Term Care on September 26, 2007. She began the month of September in a Nursing Home and ended that month in a nursing home. She was out of Long Term Care for 14 days of the month of September.

5) The claimant's niece and Power of Attorney called the NH worker on September 27, 2008, the day after her aunt's reentry in to the Nursing Home. She was inquiring about the claimant's Nursing Home coverage. The worker was not available so she left a message for her to call back about coverage. The niece left both her home and her cell phone number. The worker did not call her back. The niece called again the first and middle part of October, left messages, and phone numbers. She did not receive a call back. In late October, the niece called and left a message on the supervisor's phone. The Department mailed paper work to the niece in December to complete. The niece once again tried to call the NH worker to get instructions on how to complete the paperwork. She left a message but did not get a call back. She completed the paperwork as best she could and took them in to the Department and turned them in to the receptionist on December 27, 2008. Case comments do not note any of the phone messages, the mailing of the paperwork, or the receipt of the completed paperwork. The Department did acknowledge that they had received numerous phone messages from the niece.

6) The NH worker had her first communication with the niece on January 16, 2008. She returned a call to the niece's cell phone and left a message of an appointment January 28, 2008 to come in for a Nursing Home application. A nursing home application was taken on January 28, 2008 with the niece. By this time, the claimant's Social Security checks had mounted up in her bank account to an excess of $4,000. The claimant had not been paying any amounts to the nursing home, as her niece had not been advised as to how much her contribution would be. On January 23, 2008, she had a balance of

$3,442.33. in the bank. The Department looked at the January 2, 2008 balance of $4026.28. She also has two life insurance policies with a total cash-in value of $883.17.

7) The January 9, 2008 denial letter referred to a September 11, 2007 application date however; no actual application had been made and the Department did not obtain verification of assets back to September. A notice was mailed to the niece on February 12, 2008 advising of an eligibility date of February 1, 2008 with the client's contribution toward care calculated at $644.00 per month. The application was approved for Nursing Home payment to begin February 1, 2008 due to assets in excess for previous months.

8) The claimant's niece provided in Exhibit (C-1) verification of the claimant and her husband's joint bank account showing a September 10, 2007 balance of $3,111.77. Exhibit (C-2) verifies a balance of $3481.78 for October 9, 2007. Each of these statements show deposits of both the claimant and her husband's Social Security checks equaling $1,459. If this $1,459. were subtracted from the October balance of $3481.78 an amount of $2022.78 would remain and considered as an asset along with the $883.17 Life Insurance cash-in-value. This would result in countable assets in October of $2910.95 for the month of October. Had the Department promptly returned the niece's phone called and processed her request for Nursing Home care, this October bank statement would have been considered for October. The average cost of Nursing Homes in WV is $5087. The excessive assets of $910.95 would have been applied against this average cost for October benefit calculation.

9) The Department concedes that the Department owes for Nursing Facility care for the month of September, as all assets would be attributed to the community spouse. The Department's witness testified that payment would be issued for September.

10) In the January 9, 2008 letter, Exhibit D-4, the Department acknowledged their awareness of an application for Nursing Home benefits in September however; considered the assets verified in January to deny coverage for September 2007 thru January 2008.

11) WV Income Maintenance Manual §1.2

> Worker Responsibilities:
> The Worker has the following general responsibilities in the application process.
>
> - Inform the client of the benefits the Department offers.
> - Accept an application from any person or his representative who wishes to apply.
> - Ensure the client is given the opportunity to apply for all of the Department's Programs on the date that he expresses an interest.
> - Obtain all pertinent, necessary information through verification, when appropriate
> - Inform the client of his responsibilities, the process involved in establishing his eligibility, including the Departments processing time limits, and how the beginning date of eligibility is determined.

Right to Information:

All those who have applied for benefits, or who inquire about the requirements for receiving benefits, must have the requested information provided. This includes a general explanation of the eligibility requirements and answers to specific questions.

12) WV Income Maintenance Manual Chapter §2.4

4. AG Closures:

In no instance is Medicaid Coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is determined based on case record information. The client may be required to visit the office only for completion of a Social Summary for a MRT referral.

13) WV Income Maintenance Manual Chapter §17.1 (Long Term Care)

In determining eligibility for payment of nursing or alternative care, the Worker must ensure that the client, or his representative, is fully informed of the policies and procedures. This is necessary so that the client, his family or his representative is able to make informed decisions about the client's financial affairs.

14) WV Income Maintenance Manual Chapter §17.3 (Long Term Care)

C. DISCHARGES AND CLOSURES

When a client is no longer in need of nursing facility care or returns home, eligibility for nursing facility services ends after the notice period expires.

Upon discharge, the Worker must:

- Evaluate the client for all Medicaid coverage groups.

15) WV Income Maintenance Manual Chapter §17.10 (Long Term Care)

ASSET ASSESSMENTS

When determining eligibility for nursing facility services for an individual, institutionalized on or after 9/30/89, and who has a community spouse, the Worker must complete an assessment of the couple's combined countable assets. The assessment is completed, when requested by the client or his representative, prior to application, or at application, if not previously completed. It is completed as of the first continuous period of institutionalization and is completed one time only.

The purpose of the Asset Assessment is to allow the spouse of an institutionalized individual to retain a reasonable portion of the couple's assets and to prevent the impoverishment of the community spouse.

1. Determine the FMV of the couple's combined countable assets, as of the beginning of the first continuous period of institutionalization.
2. Compare the amount from step 1 to $20,880. If the Step 1 amount is equal or less than $20,880, all assets are attributed to the community spouse.

The asset assessment may be revised when the client, his spouse, the Hearings Officer or the Worker determine, with supporting documentation, that the initial determination was incorrect or based on incorrect information.

16) WV Income Maintenance Manual §11.3
Maximum Allowable Assets
SSI-Related Medicaid AG 1 $2,000

VIII. CONCLUSIONS OF LAW:

1) Policy §2.4 provides that no Medicaid Coverage should stop without consideration of Medicaid eligibility under other coverage groups. When the husband of this claimant contacted the Department to advise that his Aged Disabled Waiver wife was going into the Nursing Home, the Department should have converted coverage for payment to the Long Term Care facility.

2) Policy §17.10 dictates that the couple's combined assets $20,880 or less are attributed to the community spouse. Assets should not have been an issue in September as their total assets were well below this figure. Once the husband had passed away then another assets assessment would have been warranted to determine if the claimant's assets exceeded the maximum of $2,000.

3) Policy §1.2 states that the Worker's responsibility is to, "Ensure the client is given the opportunity to apply for all of the Department's Programs on the date that he expresses an interest." It further states that, "All those who have applied for benefits, or who inquire about the requirements for receiving benefits, must have the requested information provided." Policy §17.1 provides that the worker must, in determining eligibility for nursing care, ensure that the client, or his representative, is fully informed of the policies and procedures. It states that this is necessary so that the client, his family or his representative is able to make informed decisions about the client's financial affairs. The Department failed to follow all of the above protocol.

4) Policy in §17.10 provides that an asset assessment may be revised when the Hearings Officer determines, with supporting documentation, that the initial determination was incorrect or based on incorrect information. The asset assessment in this case was computed incorrectly with incorrect information used.

5) Had the Department followed policies and protocol in this case, the NH Worker would have followed up on the information given to her by the husband and the ADW case manager and converted the ADW Medicaid case to a Long Term Care NH case for September. She would have then adjusted the asset assessment for October or most likely November since the death of the spouse was late in the month of September. Nursing facility eligibility would have continued with an adjustment in the client's contribution amount for one month due to the excessive asset amount of $910.95.

6) Indications are that this claimant was brought home from the Nursing Facility for a two-week period to be with her husband before he died. She most likely remained eligible for ADW for this short period however, consideration for this coverage was not given by the Department. The worker noted that she merely closed the Nursing Home case. It is clear that the claimant's niece was unrelenting in her efforts to determine what she needed to do to ensure that Medicaid would cover her aunt's nursing facility care.

IX. DECISION:

After reviewing the testimony presented during the hearing and the examination of documents and policy found, it is the finding of this Hearing Officer that the Department was not correct in their denial of Medicaid coverage for September 2007 through January 2008. The claimant qualified for Medicaid coverage for nursing facility care for her partial stay in September and for an adjusted benefit for the month of October. Full benefits were due for the months of November through January considering the claimant's contribution amount. I am ruling to **reverse** the Department's action to deny Medicaid coverage for Long Term Care benefits for months September 2007 through January 2008.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 3rd Day of July, 2008.

_____

Sharon K. Yoho
State Hearing Officer