STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

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Cabinet Secretary

BOARD OF REVIEW
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Sheila Lee
Interim Inspector General

October 26, 2022

[redacted]

RE: [redacted], A PROTECTED INDIVIDUAL v. WV DHHR
ACTION NO.: 22-BOR-2023

Dear [redacted]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing 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.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: Ann Hubbard, BFA, [redacted]. DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN THE MATTER OF: **ACTION NO.: 22-BOR-2023**

[redacted], A PROTECTED INDIVIDUAL,

Appellant,

vs.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted], A PROTECTED INDIVIDUAL. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing convened on October 19, 2022, on appeal filed August 23, 2022.

The matter before the Hearing Officer arises from the June 24, 2022 determination by the Respondent of a transfer of resource penalty being applied to the Appellant's April 2022 resource amount for Long-Term Care (LTC) Medicaid benefits.

At the hearing, the Respondent appeared by Ann Hubbard, Economic Services Supervisor. The Appellant appeared by [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence:

Department's Exhibits:

- D-1 Hearing Summary
- D-2 [redacted] bank statement for November 9, 2021
- D-3 [redacted] bank statement for January 12, 2022
- D-4 [redacted] bank statement for February 9, 2022
- D-5 Contract for Personal Care Services for [redacted] Oct. 2021
- D-6 Contract for Personal Care Services for [redacted] Dec. 2021
- D-7 Contract for Personal Care Services for [redacted] Jan. 2022
- D-8 Medical bills for [redacted]
- D-9 Notice of eligibility for Medicaid and/or WVCHIP, dated June 24, 2022
- D-10 eRAPIDS: PRODUCTION, Long Term Care Budget, payment date April 1, 2022

D-11 West Virginia Income Maintenance Manual (IMM), Chapter 24, *Long Term Care*, §§24.7.6, 24.8.2.F.1, 24.8.2.F.2, 24.7.2.D, 24.7.2.D.1, 24.7.3, 24.8.2.J, 24.8.2.J.1, 24.8.2.J.2

Appellant's Exhibits:
None

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant was admitted to [redacted] a nursing facility located in [redacted], West Virginia, on February 10, 2022. (Exhibit D-1)

2) An application for Long-Term Care (LTC) Medicaid on behalf of the Appellant was submitted on April 15, 2022, requesting a start date of April 1, 2022. (Exhibit D-1)

3) The Appellant does not have full Medicaid coverage and is not eligible for Qualified Medicare Beneficiary (QMB) assistance benefits.

4) Because the Appellant's total monthly unearned income of $2,740.95 exceeds three times the Supplemental Security Income (SSI) amount of $2,523, the Appellant is required to meet a spenddown for SSI-related Medicaid coverage. (Exhibits D-1, D-9, and D-10)

5) After deducting $200 for the Medically Needy Income Limit (MNIL) for one and a $20 standard deduction from the Appellant's monthly gross income, the Respondent determined that the Appellant had a spenddown amount of $2,540.95. (Exhibits D-1, D-8, and D-10)

6) There was no written contract for personal care services to be provided to the Appellant prior to the services being performed by [redacted] (family friend) or [redacted] (family member).

7) There was no signed written recommendation at the time of the receipt of personal care services by the Appellant's physician as necessary to prevent the transfer of the Appellant to residential care or nursing facility care.

8) There was a withdrawal of cash by [redacted] from the Appellant's bank account in November 2021 in the amount of $2,500. (Exhibit D-2)

9) There was withdrawal of cash by [redacted] from the Appellant's bank account in January 2022 in the amount of $1,000. (Exhibit D-3)

10) There were two withdrawals of cash by [redacted] from the Appellant's bank account in February 2022 in the amounts of $2,500 and $4,400. (Exhibit D-4)

11) Medicare made a $1,628.56 payment on the Appellant's February 10, 2022 transport services bill of $1,754.

12) The Appellant's outstanding medical bills totaling $2,387.82 were paid through the February cash withdrawal of $4,400. (Exhibit D-8)

13) The Appellant has a total transfer of resource penalty for April 2022 of $8,012.18.

APPLICABLE POLICY

WV Medicaid Manual Chapter 24, §24.7.2.C, *Nursing Facility Coverage Group*, *Gross Income Test*, in part, states that if the client is not currently eligible by having QMB or full coverage Medicaid, Medicaid eligibility may be established as follows:

- If the client's gross countable monthly income is equal to or less than 300% of the current maximum Supplemental Security Income (SSI) payment for one person and the client is institutionalized, he may be eligible.
- SSI-Related Categorical Medicaid requirements (aged, blind or disabled) and asset guidelines must be met. These clients' contribution toward cost of care is determined in the post-eligibility process. There is no spenddown amount for these clients.

WV Medicaid Manual Chapter 24, §24.7.2.D, *SSI-Related/Monthly Spenddown*, states that if the client is not otherwise eligible by having QMB, full coverage Medicaid, or Nursing Facility coverage group, his eligibility as an SSI-Related Medicaid client with a monthly spenddown must be explored. All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount.

WV Medicaid Manual Chapter 24, §24.7.2.D.1, *Spenddown Calculation*, in part, explains that when the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. If the monthly spenddown amount exceeds the monthly Medicaid rate for the facility, the client may become eligible for Medicaid based on a six-month period of consideration (POC), but not for payment of nursing facility services. The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates are found only on the Division of Family Assistance (DFA) intranet page. The rates are updated at least semi-annually. Any requests for the rates must be made under the Freedom of Information Act (FOIA) to the Department of Health and Human Resources (DHHR) Office of the Deputy Secretary, Division of Accountability and Management Reporting.

WV Medicaid Manual Chapter 24, §24.7.6, *Determining The Client's Total Contribution*, states that if the individual is a full Medicaid coverage client or in the Nursing Facility Medicaid coverage group without a spenddown, the resource amount determined in the post eligibility process from above is his total cost contribution. Because the amount of medical expenses used to

meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care, unless the client has a community spouse. This amount is added to the resource amount determined above to determine the client's total monthly contribution toward the cost of his nursing care.

WV Medicaid Manual Chapter 24, §24.8.2.C, ***Transfers That Are Not Permissible,*** instructs in pertinent part, that all transfers not specified as permissible result in an application of a penalty.

WV Medicaid Manual Chapter 24, §24.8.1.D, ***Revisions to the Asset Assessment***, allows the Asset Assessment only to 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.

WV Medicaid Manual Chapter 24, §24.8.2.A.7, ***Look-Back Period***, mandates that the look-back period is the length of time for which the Worker looks back for any resource transfers. The look-back period is 60 months, whether or not a trust fund was involved. The look-back time period begins the month the client is both institutionalized and has applied for Medicaid.

WV Medicaid Manual Chapter 24, §24.8.2.F, ***Transfer to Pay for Personal Care Services,*** **§24.8.2.F.1,** ***Non-permissible Transfer of Resources to Pay for Personal Care Services***, explains that personal care services provided to an individual by a relative or friend are presumed to have been provided for free, at the time rendered, when a Personal Care Contract (PCC) did not exist. Therefore**, a transfer of resources from an individual to a relative or friend for payment of personal care services is an uncompensated transfer without FMV received for the transferred resource and subject to a penalty, unless the services were provided in accordance with the requirements below.** See Section 24.8.2.A.1 regarding FMV. [Emphasis added]

WV Medicaid Manual Chapter 24, §24.8.2.F.2, ***Permissible Transfer of Resources to Pay for Personal Care Services***, in pertinent part, instructs that a transfer of resources by an individual to a relative or friend to pay for personal care services rendered may be a permissible transfer if the personal care services were performed through an eligible PCC, also known as a personal care agreement or personal service contract. The PCC must meet all of the following criteria.

➢*Requirements Regarding the Contract* - The following describes the requirements regarding the contract:

- A PCC exists between the individual or his authorized representative and the caregiver.
- The duration of the PCC is actuarially sound.
- **The terms of the PCC are in writing between the individual or his authorized representative and the caregiver**. [Emphasis added]
- The PCC is reviewed by the Worker for compliance;
- The terms of the Contract include:
    1. A detailed description of the services provided to the individual in the home;
    2. The frequency and duration of the services provided. The services must be measurable and verifiable and the compensation to the caregiver paid at a reasonable amount of consideration, i.e., money or property. Payment must be clearly defined

either as a set amount or an amount to be determined by an agreed-upon hourly rate that will be multiplied by the hours worked; and,

3. Services expected of the caregiver, if any, during any period the individual may reside in an assisted living, skilled nursing, or other type of medical or nursing care facility on a temporary basis between stays at home.

➢*Requirements Regarding the Provision of Services* - The following describes the requirements regarding the provision of services:

- Services paid from transferred resources must be rendered after the written agreement was executed between the individual and the caregiver;
- A PCC may be in place at the time of the individual's stay in a nursing facility or a similar placement; however, it is assumed, unless proven otherwise, that personal care services during this time are provided by staff rather than the caregiver named in the PCC; and,
- **At the time of the receipt of the services, the services must have been recommended in writing and signed by the individual's physician as necessary to prevent the transfer of the individual to residential care or nursing facility care**. Such services may not include the mere providing of companionship. [Emphasis added]

➢*Requirements Regarding the Transfer* - The following describes the requirements regarding the transfer:

- The transfer to the relative or friend acting as caregiver must have taken place at the time the personal care services were rendered;
- The transfer cannot be for services projected to occur in the future, but must be paid for at the time rendered; and,
- FMV must be received by the caregiver in the form of payment for personal care services provided to him. The Worker must determine if reasonable payment for personal care services occurred.

DISCUSSION

The Appellant was admitted to [redacted], a nursing facility located in [redacted], West Virginia, on February 10, 2022. An application for LTC Medicaid was made on her behalf requesting coverage from April 1, 2022. The Appellant has monthly gross unearned income from Social Security of $2,261.10 and a pension of $479.85. The total of the Appellant's monthly gross unearned income of $2,740.95 exceeded three times the SSI amount of $2,523, which resulted in the Appellant having a spenddown amount. This spenddown amount was calculated by disregarding $200 for medically needy income limit for one, less a $20 standard deduction, resulting in a spenddown amount of $2,520.95.

When examining the Appellant's assets, transfers of cash in the amount of $2,500 on November 4, 2021, $1,000 on December 23, 2021, $2,500 on January 27, 2022, and $4,400 on February 7, 2022 were discovered. On June 24, 2022, the Respondent issued a notice of Medicaid eligibility which included a patient responsibility of $12,920.95 for the month of April 2022. The Appellant's representative appeals the Respondent's decision to apply a transfer of resources penalty to the total of the Appellant's April 2022 resource amount.

Policy allows for a transfer of resources by an individual to a relative or friend to pay for personal care services rendered if the services were performed through an eligible personal care contract

(PCC). Policy lists the specific criteria that the PCC must meet in order to be considered a permissible transfer, otherwise, it is deemed as non-permissible. Among the listed criteria is the requirement that at the time of the receipt of the services, the services must have been recommended in writing and signed by the individual's physician as necessary to prevent the transfer of the individual to residential care or nursing facility care. There was no evidence presented to show that the Appellant's physician made this recommendation in writing.

Policy also requires that in order to be considered a permissible transfer of resources for personal care services, a signed written contract (PCC) prior to the services being rendered must be in place. The Appellant's representative, [redacted], testified that there were no written contracts in place for the personal care services being rendered because she was not made aaware that this was necessary to qualify for LTC Medicaid. Moreover, [redacted] asserted that at that the time nursing home placement was not a consideration. [redacted] stated that family and friends verbally agreed to provide care to the Appellant. Specifically, [redacted], a family friend, cared for the Appellant in October and December 2021, and [redacted], a family member, provided care to the Appellant in January 2022. A total of $6,000 was withdrawn from the Appellant's bank account in cash to pay these individuals.

Because there was no written signed PCC executed prior to the services being rendered, the cash withdrawal of the $6,000 does not meet the policy requirement for a permissible transfer of resources to pay for personal care services. Although [redacted] asserted these transfers were not made for the exclusive purpose of qualifying for Medicaid, which policy excludes from penalty, policy specifically mandates that personal care services provided by family/friends which do not meet criteria to be considered as permissible, must incur a transfer penalty. Policy mandates that non-permissible transfer of resources result in a penalty.

Additionally, the $4,400 cash withdrawal to pay for the Appellant's outstanding medical expenses was not corroborated by the evidence presented. The total amount presented showed payment of outstanding medical bills in the amount of $2,387.82 as follows:

- $147.57 ([redacted]),
- $21.52 ([redacted] Specialists),
- $26.78 ([redacted] Senior Care),
- $86.96 ([redacted] Health Associates)
- $233 ([redacted] Transport 1/1/22 call),
- $531 ([redacted]),
- $20.76 ([redacted] Medical Center),
- $1,194.79 ([redacted] Transport 1/24/22 call), and
- $125.44 [redacted] Transport 2/10/22 call).

Therefore, because a total of paid outstanding medical bills of $2,387.82 was shown to have been made out of the $4,400 cash withdrawal made from the Appellant's account, a transfer penalty of $2,012.18 must be applied.

The Appellant has a total transfer of resource penalty for April 2022 of $8,012.18 ($6,000 non-permissible transfer of resources for personal care services + $2,012.18 cash withdrawal). When

the total of transfer of resource penalty is added to the Appellant's spenddown amount of $2,520, the total of the Appellant's resource amount for the month of April 2022 is $10,532.18.

CONCLUSION OF LAW

1) Policy allows transfers of resources for personal care services provided by family members or friends if it meets specific criteria. If the personal care services do not meet all the listed criteria, any transfer of resources to pay for the services are considered as non-permissible.

2) The policy requirement of a signed written contract (PCC) prior to personal care services being provided was not met.

3) The policy requirement that the Appellant's physician recommend in writing that the personal care services are necessary to prevent the transfer of the Appellant to residential care or nursing facility care was not met.

4) The total of $6,000 cash withdrawals to pay for personal care services provided by [redacted] were not permissible and is subject to a transfer penalty.

5) The evidence provided showed that $2,387.82 of outstanding medical expenses were paid by the February 2022 cash withdrawal of $4,400.

6) A total transfer penalty of $8,012.18 must be applied to the Appellant's resource amount.

7) Because the Appellant's gross monthly unearned income of $2,740.95 exceeds three times the SSI amount of $2,523, a spenddown amount must be applied.

8) The Appellant has a spenddown amount of $2,520.

9) The total of the Appellant's resource amount for April 2022 is $10,532.18.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to apply a transfer penalty but is **REMANDED** to determine the proper amount of the penalty as determined in this decision.

ENTERED this 26th day of October 2022.

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Lori Woodward, Certified State Hearing Officer