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

**Bill J. Crouch**
**Cabinet Secretary**

**BOARD OF REVIEW**
**4190 Washington Street, West**
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**Jolynn Marra**
**Interim Inspector General**

April 23, 2019

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.:19-BOR-1304

Dear Ms. [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,

Danielle C. Jarrett
State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29
cc: Misty Fielder, Department Representative

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**BOARD OF REVIEW**

[redacted],

**Appellant,**

**v.** **Action Number: 19-BOR-1304**

**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]. 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 was convened on April 2, 2019, on an appeal filed February 12, 2019.

The matter before the Hearing Officer arises from the February 5, 2019 decision by the Respondent to deny Long-Term Care (LTC) Medicaid for the months of November and December 2018 due to excessive assets.

At the hearing, the Respondent appeared by Misty Fielder, Department Representative. Appearing as witnesses for the Appellant were [redacted], Durable Unlimited Power of Attorney (POA); and [redacted], Business Office Director, [redacted]. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

**Department's Exhibits**:

| | |
|---|---|
| D-1 | Durable Unlimited Power of Attorney (POA), dated December 9, 1997 |
| D-2 | West Virginia Department of Health and Human Resources (DHHR) Application for Long-Term Care (LTC) Medicaid and Children with Disabilities Community Service Program (CDCSP), dated December 17, 2018 |
| D-3 | Written Verification Checklist, dated December 21, 2018; Notice of Verification, dated January 7, 2019 |
| D-4 | West Virginia Income Maintenance Manual (WV IMM) §§ 24.12.2.A through 24.12.2.B |
| D-5 | WV IMM § 24.4.1.C.10 |
| D-6 | Pre-Admission Screening (PAS), dated August 21, 2017 |
| D-7 | PAS, dated September 28, 2017 |

D-8 PAS, dated December 12, 2017
D-9 PAS, dated August 6, 2018
D-10 PAS, dated January 24, 2019
D-11 WV IMM § 5.3.1.B
D-12 WV IMM § 5.4; WV IMM § 5.5.4; WV IMM §§ 5.5.6.A through 5.5.6.B; WV IMM § 5.5.27; and WV IMM § 7.3
D-13 Correspondence from American General Life Insurance Company, dated July 24, 2018
D-14 Correspondence from [redacted] to American General Life Insurance Company, dated January 11, 2019
D-15 Statement of Taxes Due with attached copy of written check; [redacted] County Receipt for Taxes & Fees Paid; Title to Vehicle, dated December 21, 2018
D-16 Correspondence from [redacted] and Policyowner Services Request, dated December 9, 1997; Policy Schedule, dated September 12, 1975; and Policy Specifications, dated September 3, 1968
D-17 Itemized Burial Contract, dated July 5, 2018
D-18 JP Morgan Chase Bank- Checking Account, dated July 17, 2018 through August 14, 2018; Checking Account, dated August 15, 2018 through September 17, 2018; and Copy of [redacted] and Copies of Written Checks, dated August 29, 2018
D-19 JP Morgan Chase Bank – Checking Account, dated October 16, 2018 through November 15, 2018; Copy of Written Check, dated December 17, 2018; Copy of Written Check, dated December 28, 2018; Copy of Written Check, dated December 17, 2018; Copy of [redacted] Bill, dated November 30, 2018; Copy of [redacted], dated November 29, 2018
D-20 JP Morgan Chase Bank - Printed Online Statement, dated July 25, 2018 through January 3, 2018
D-21 Notice of Decision, dated January 23, 2019
D-22 Notice of Decision, dated March 19, 2019
D-23 Notice of Decision, dated February 5, 2019
D-24 Notice of Decision, dated February 5, 2019
D-25 Notice of Decision, dated March 19, 2019
D-26 Notice of Decision, dated October 23, 2018
D-27 eRAPIDS computer system screenshot printout of Long-Term Care Budget for November and December 2018; and Notice of Decisions, dated March 19, 2019
D-28 Social Security Benefit Amount, dated December 22, 2018
D-29 WV IMM §§ 24.7.3 through 24.7.7
D-30 [redacted] Statement of Charges, dated January 2019; [redacted] County Emergency Ambulance Authority bill, dated December 28, 2018
D-31 eRAPIDS computer system screenshot printout of Long-Term Care Budget for September 2018, dated September 1, 2018
D-32 eRAPIDS computer system screenshot printout of Long-Term Care Budget for January 2019, dated January 1, 2019
D-33 eRAPIDS computer system screenshot printout of Long-Term Care Budget for February 2019, dated February 1, 2019
D-34 Notice of Contribution to the Cost of Care, dated February 4, 2019
D-35 Corrected Notice of Contribution to the Cost of Care, dated March 18, 2019

**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 applied for Long-Term Care (LTC) Medicaid benefits on December 17, 2018, requesting back-dated coverage to ensure eligibility from November 2018 and ongoing for unpaid medical expenses. (Exhibit D-2)

2) [redacted] is the Appellant's POA and has served in that capacity since December 9, 1997. (Exhibit D-1)

3) As of January 1, 2019, the Appellant owed [redacted] (Nursing Facility) $106,150.50. (Exhibit D-30)

4) In order to evaluate the Appellant for a possible remedial deduction, the Respondent issued a verification checklist on January 7, 2019, to the Appellant and requested submission of a PAS dated on or after October 22, 2018, bank account balances from October 1, 2018 through January 1, 2019, verification of the cash surrender value for Life Insurance Policy - [redacted], and an itemized nursing home bill from July 2018 through January 2019. The notice further indicated that "if the information needed is not made available to the Department by January 17, 2019, your application will be denied, deduction will not be allowed, and effective date for Medicaid Long-Term Nursing (MLTN) coverage would be September 1, 2018 and the effective date of the Qualified Medicare Beneficiary (QMB) coverage would be January 1, 2019." (Exhibit D-3)

5) The Appellant's POA returned all the requested information to establish the remedial deduction in the amount of $81,251.25. (Exhibit D-35)

6) Valid PAS's were submitted to establish eligibility for the months of August 2018 through January 2019. (Exhibits D-8 and D-9)

7) The Appellant's total countable assets for November 2018 were $2,526.35. (Exhibit D-20)

8) The Appellant's total countable assets for December 2018 were $3,338.48. (Exhibit D-20)

9) Between November 8 through November 30, 2018, payments were issued from the Appellant's checking account in the amount of $58.87. (Exhibit D-19)

10) Between December 12 and December 28, 2018, checks were issued from the Appellant's checking account in the amount of $2,690.51. (Exhibit D-20)

11) Beginning January 1, 2019, the Appellant's total countable assets were $293.97. (Exhibit D-20)

## APPLICABLE POLICY

WV IMM § 1.2.4, states the client's responsibility is to provide complete and accurate information about his or her circumstances so that the worker can make a correct determination about his or her eligibility.

WV IMM § 5.3.1.B Supplemental Security Income (SSI) Medicaid Groups provides in part:

The asset eligibility determination for these applications must be made as of the first moment (defined as 12:00 a.m. of the first day) of the month of eligibility. The client is not eligible for any month in which countable assets are in excess of the limit, as of the first moment of the month. (emphasis added) Increases in countable assets during the one month do not affect eligibility unless retained into the first moment of the following month.

If the applicant's assets, as of the first moment of the month, are within the asset limit, and during the month his assets increase to above the asset limit, he is still eligible for that month.

The Worker may use any of the following items to determine first-of-the-month account balances:

- Printed or online bank statements and passbooks;
- The applicant's check register or any bank-issued document. This includes, but is now limited to, ATM transaction receipts and/or deposit and/or withdrawal receipts; and/or
- The account transaction history on a bank's automated telephone customer service line that provides complete transaction information, (i.e., deposits, withdrawals, cleared checks, and transfers to/from the account with transaction dates).

When the applicant states that a check has not cleared the bank, the Worker may use any of the means listed above to verify that the funds are legally obligated. (emphasis added)

WV IMM § 5.4 reads SSI-Related Medicaid asset limit for a one-person Assistance Group (AG) is $2,000. (emphasis added)

WV IMM § 24.4.1.C.10 Payment for Nursing Facility Services provides in part:

Payment for nursing facility services begins on the earliest date the three conditions described below are met simultaneously. Payment for nursing facility services may be backdated up to three months prior to the month of application when all conditions described below are met for that period.

- The client is eligible for Medicaid; and
- The client resides in a Medicaid-certified nursing facility; and
- There is a valid PAS or, for backdating purposes only, physician's progress notes or orders in the client's medical records.

WV IMM § 24.7.3 explains in determining the client's contribution towards his cost of nursing facility care, the Worker must apply only the income deductions listed. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute towards his cost of care.

WV IMM § 24.7.3.A.1 explains this amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. For most residents, the monthly amount deducted is $50. An individual receiving SSI will have his monthly allocation reduced to $30, which is his monthly Personal Needs Allowance (PNA) if he is in the facility for at least three (3) months.

WV IMM § 24.7.3.A.5 explains certain non-reimbursable medical expenses for the eligible client only may be deducted in the post-eligibility process. These expenses are sometimes referred to as "remedial expenses." Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual. A non-reimbursable medical expense may be permitted only for services provided in the month of application and the three months prior to the month of application. This includes nursing facility expenses incurred during the three months prior period when the client was ineligible for Medicaid due to excessive income. Only a current payment on, or the unpaid balance of, old bills incurred outside the period of consideration (POC) may be permitted as an non-reimbursable medical expense. Charges for an ambulance or transportation which is medically necessary for an individual in a nursing facility who is Medicaid and/or Medicare eligible or has private insurance cannot be used as a deduction for non-reimbursable medical expenses. (emphasis added)

WV IMM § 24.7.6 reads 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.

WV IMM § 24.12.2.A explains before payments for nursing facility services can be made, medical necessity must be established for the client. (emphasis added) The PAS is the tool used for this purpose. The PAS is signed by a physician and then evaluated by a medical professional working with the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form, which is the only date used for establishment of medical necessity.

(emphasis added)

WV IMM § 24.12.2.B explains a previously approved PAS may be used for backdated eligibility and payment for nursing facility services, so long as the client has remained in the same facility since completion of the previously approved form.

## DISCUSSION

In order to be eligible for LTC Medicaid, an applicant must meet three conditions simultaneously: 1) must be eligible for Medicaid; 2) must reside in a Medicaid-certified nursing facility; and, 3) must have valid PAS or, for backdating purposes only, physician's progress notes or orders in the client's medical records. Payment for nursing facility services may be backdated up to three months prior to the month of application when all these conditions are met.

There was no dispute regarding the second and third criteria for LTC Medicaid eligibility listed above. The issue on appeal arises from the Respondent's finding that the Appellant was over the asset limit for Medicaid eligibility for the months of November and December 2018.

The Appellant applied for LTC Medicaid on December 17, 2018, requesting back-dated coverage to ensure eligibility from November 2018 and ongoing for unpaid medical expenses. The Respondent testified the asset limit for a one-person AG for Medicaid is $2,000.

In determining the countable assets for a potential month of Medicaid eligibility, the assets as of 12:00 a.m. on the first day of that month are considered. Between November 8 through November 30, 2018, payments were issued from the Appellant's checking account in the amount of $58.87 but were non-excludable assets for November 2018. Because the Appellant had $2,526.35 in countable assets as of November 1, 2018, she was ineligible for Medicaid for that month. Between December 12 and December 28, 2018, checks were issued from the Appellant's checking account in the amount of $2,690.51 but were non-excludable. The Appellant had $3,338.48 in countable assets as of December 1, 2018, which were in excess of the $2,000 limit to be Medicaid eligible for the month of December 2018.

The Appellant's POA contended the November and December payments made from the Appellant's checking account should have been excluded in the asset calculation. However, policy is clear that only checks which were written prior to the first day of the month being evaluated are considered to be legally obligated. Because payments made and checks submitted by the Appellant's POA indicated that the payments and checks were made after November 1, 2018 and December 1, 2018, they cannot be excluded as countable assets for evaluation of eligibility for November and December 2018.

The Appellant's POA further argued that the Respondent failed to tell her that the Appellant's Medicaid had an asset limit of $2,000 and that it was her understanding that DHHR would seize the Appellant's assets to pay for her nursing home care. The Appellant's POA testified she held the Appellant's monthly bills and funds in her checking account until the she was deemed eligible for LTC Medicaid. The Appellant's POA testified that it was not the Appellant's fault that she was

over the asset limit because she did not know she needed to have less than $2,000 in the Appellant's checking account for the first of the month. There are no exemptions to the Medicaid asset limit policy.

As of January 1, 2019, the Appellant's total countable assets were $293.97. The Appellant met the three conditions for LTC Medicaid eligibility at that time.

As of January 1, 2019, the Appellant owed the Nursing Facility $106,150.50. On January 17, 2019, the Respondent issued a notice of possible remedial deduction with an attached verification checklist to the Appellant. The Appellant's POA returned all the requested information to establish the remedial deduction in the amount of $81,251.25. The Respondent testified that beginning January 1, 2019, the Appellant was responsible for paying $983.50 each month towards her remedial deduction.

Per policy, an applicant for LTC Medicaid coverage is not eligible for any month in which countable assets are in excess of the limit, as of the first moment of the month. Whereas, the Appellant's assets were in excess of the allowable amount for a one-person AG of $2,000, the Respondent correctly denied LTC Medicaid coverage for November and December 2018.

## CONCLUSIONS OF LAW

1) Because the Appellant's countable assets as for the first moment of the month were $2,526.35, the Appellant's asset for November 2018 were excess of the $2,000 limit.

2) The Appellant's November 8 through November 30, 2018 payments are not deducted from the Appellant's countable assets for November 2018 because the payments were made after November 1, 2018.

3) Because the Appellant's countable assets as for the first moment of the month were $3,338.48, the Appellant's asset for December 2018 were excess of the $2,000 limit.

4) The Appellant's December 17 and December 28, 2018 checks are not deducted from the Appellant's countable assets for December 2018 because the checks were written after December 1, 2018.

5) The Respondent correctly denied the Appellant's LTC Medicaid coverage for the months of November and December 2018 based on excess of assets.

## DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's action to deny the Appellant's LTC Medicaid coverage for the months of November and December 2018 based on excessive assets.

**ENTERED this _____ day of April 2019.**

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**Danielle C. Jarrett**
**State Hearing Officer**