	The Delaware Code (31 Del. C. §520) provides for judicial review of hearing decisions. In order to have a review of this decision in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections can be made.

In Re: Redactedv. DMMA **DCIS No. Redacted**

Appearances: Nicole Kearns, Westminster Village Pro-hac Vice Attorney Appearing on Behalf of Redacted, **Appellant**
Margaret F. England, Delaware Attorney Sponsoring Pro-hac Vice Attorney, Nicole Kearns
Valerie Fischel, Business Office Manager at Westminster Village, Witness for the Appellant
Redacted, Guardian of Redacted's Property as of May 15, 2009, Witness for the Appellant

Peter Feliceangeli, DAG, Attorney for Division of Medicaid and Medical Assistance, **Appellee**
Kimberly Hovington, Social Worker/Case Manager for DMMA Team 335, Witness for the Appellee

I. Background

Appellant, Redactedhas been a resident of Westminster Village was approved for long-term care benefits on December 1, 2009. Westminster Village faxed an application to the Division of Medicaid and Medical (DMMA) on Redacted behalf on April 17, 2009 seeking recoupment for unpaid nursing home care bills from February 2008 through April 2009. DMMA argues that no action was taken on this application because it was incomplete. A subsequent application was received by DMMA, filed by the Guardian of Redacted property, Redacted, on July 29, 2009. On February 23, 2010, DMMA denied this application for exceeding the resource limit. Westminster Village requested a Fair Hearing on Redacted's behalf challenging DMMA's decision on the belief that Ms. Bowen's resources were calculated incorrectly.

A Pre-Hearing Brief was filed by Westminster Village on behalf of the Appellant on May 26, 2010. DMMA filed its response brief on May 28, 2010. These Briefs have been accepted as part of the record by the Hearing Officer and have been incorporated by reference.

A Fair Hearing concerning this appeal took place on June 3, 2010. This is the Hearing Officer's Decision regarding the matter.

II. Summary of Evidence

Valerie Fischel, Credit and Collections Coordinator for Presbyterian Senior Living (Westminster Village) at the corporate office located in Dillsburg, Pennsylvania, was sworn in and testified on behalf of the Appellant. Ms. Fischel testified that in the course of supporting the corporate business office, her department routinely submits Medicaid applications on behalf of patients. Ms. Fischel stated that she submitted an application on behalf of Ms. Bowen on April 20, 2009 by utilizing the form found on DHSS's website. Ms. Fischel identified Exhibit A of the Appellant's Pre-Hearing Brief as the application she filed by UPS. Ms. Fischel testified that her intent in filing the application was to apply for medical assistance for Ms. Bowen.

Ms. Fischel testified that no one from DMMA ever called her in reference to the application and stated that she has filed for medical assistance for patients on the same form in the past. Ms. Fischel did concede however, that she did not send a cover letter with Ms. Bowen's application as she had done with previous similar applications and did not herself follow-up with DMMA to check the status of the application.

Ms. Kearns moved to admit two (2) similarly incomplete but submitted Medicaid applications of other applicants that were processed by DMMA as proof of business habit. Mr. Feliceangeli objected on the ground that each case is decided on its own facts and circumstances and these applications cannot be offered as evidence that Ms. Bowen's April 19, 2009

application should have been approved. The Hearing Officer sustained Mr. Feliceangli's objection on the basis that too many unknown factors could have made these applications processable as opposed to Ms. Bowen's. Unless Ms. Kearns can show how these two (2) applications had similar facts and circumstances *following the filing of the incomplete application*, they are not reliable and are inadmissible[1].

Redacted, Appointed Guardian of Redacted's Property as of May 15, 2009, was sworn in and testified on behalf of the Appellant. Ms. Miller testified that she filed an application for medical benefits on behalf of Ms. Bowen in July 2009 at the request of Presbyterian Senior Living. She stated that in the process of reviewing Ms. Bowen's estate, she found five (5) American General Life and Accident Insurance (AGLA) policies. She stated that per her recollection, the total surrender value for all of the policies combined was around $4,200.00. Once found, Ms. Miller attempted for weeks to cash the policies in so she could spend them down in order to reduce Ms. Bowen's resource limit to an acceptable level. She stated that she made several calls to AGLA but each time she would always get someone different who would advise her that although she was the guardian of Ms. Bowen's property she could not cash out the policies. Ms. Miller stated that she would show AGLA the relevant and applicable statute that does in-fact allow her to assign insurance benefits but AGLA retorted that per their policy she would have to obtain a court order to do so.

Ms. Miller stated that instead of a court order, she attempted to assign them into an irrevocable burial reserve, believing that this might be a little faster and still accomplish her goal. She stated that she contacted Pippin Funeral Homes in August 2009 who advised her that she

[1] Ms. Kearns continued to insist that the purpose of submitting copies of the two (2) other almost blank applications similar to Ms. Bowen's April 19, 2009 application, was to counter DMMA's contention that the reason Ms. Bowen application was not processed was because Ms. Fischel submitted the wrong form. However, the State was not arguing that the April 19, 2009 application was not processed because it was on the wrong form, but rather, because the application did not indicate what Ms. Bowen was applying for.

would have to sign an irrevocable burial reserve form which she initially did around August 4, 2009. Ms. Miller testified that it took three (3) tries to get the form completed to AGLA's satisfaction but she did not remember if she provided DMMA with the copies at that time but she was informed by DMMA that the paperwork was insufficient in October 2009. In a "We Need" letter DMMA advised Ms. Miller that it needed evidence from AGLA that the benefits had been irrevocably assigned to Pippin Funeral Home (see Exhibit D to Appellant's Pre-Hearing Brief). Ms. Miller testified that after weeks of attempting to obtain this proof from AGLA, AGLA finally advised her that she would need to obtain a court order stating that she has the authority to assign the insurance benefits. The court order specifying giving her authority to assign was issued on November 4, 2009 after she filed an Emergency Petition. Ms. Miller then provided DMMA with faxed copies of the verification of assignment for each of the policies she received thereafter from AGLA which had an effective date of November 11, 2009.

Ms. Miller testified that in addition to cashing out the insurance policies, there were a few other issues holding up Ms. Bowen's application including her $50.00 per month pension.

Ms. Miller established that pursuant to the "We Need" letters from DMMA, she provided copies of Ms. Bowen's Citizens Bank statements. She acknowledged that she made a payment to Westminster Village in the amount of $3,500.00 in order to spend down Ms. Bowen's account and sent DMMA notice through a letter received on December 14, 2009. The State admitted this letter with accompanying Citizens Bank statements as *Exhibit #2* without objection. Ms. Miller explained that the reason why Ms. Bowen's account was so high during those months was because she received accumulated back pension that was owed to her.

Kimberly Hovington, Social Worker/Case Manager for DMMA Team 335, was sworn in and testified on behalf of DMMA. Ms. Hovington testified that she has been working for

DMMA for twenty (20) years as a Social Worker/Case Manager at the Dover, Delaware office and was assigned Redacted's case.

Ms. Hovington testified that applications are reviewed by a social service technician prior to coming to a social worker like herself for processing. She stated that the technician looks through the application and decides whether the application is valid and where it should go from that point. Ms. Hovington surmises that perhaps the technician was not sure what services were being applied for, and therefore neither she, nor anyone else, was forwarded Ms. Bowen's April 19, 2009 application when it was received. She testified that she did not see the April 19, 2009 application until it was forwarded to her with the July 29, 2009 application.

Ms. Hovington acknowledged that she had been working with Redacted throughout the application process. Ms. Hovington testified that some of the issues that were holding up Ms. Bowen's application were verification of Ms. Bowen's pension, the cash value of the AGLA insurance policies ($4,174.20), and the Citizens Bank account both causing Ms. Bowen to exceed the $2,000.00 resource limit from July 2009 through November 2009. Ms. Hovington explained that the reason the accrued surrender value of all five (5) of AGLA's policies on the denial letter summaries is less than their accumulated value of $4,174.20 she just testified to, is because the amount was reduced by a $1,500.00 burial allowance she applied.

Ms. Hovington stated that the assignments executed by Ms. Miller initially were not acceptable as proof of the assignment by Medicaid because such assignments must be irrevocably assigned to a Funeral Director in order to fund a pre-paid burial in the same amount. In addition, confirmation from the insurance companies that the insurance policies had been assigned is also required and she does not recall when she received such confirmation from AGLA, but knows that the effective date was November 11, 2009. She testified that the reason

Ms. Bowen was still not approved was because her resources in her Citizens Bank account still exceeded the $2,000.00 limit. She stated that this account was not spent down until December 15, 2009 per Ms. Bowen's December 2009 bank statement and that Ms. Bowen was subsequently approved as of December 1, 2009.

Ms. Hovington affirmed that she did not receive assignment forms from Ms. Miller in August 2009, but rather just documentation verifying the pre-arranged burial expenses. Ms. Hovington stated that she did not received the first forms of assignment from Ms. Miller until September 21, 2009 and conceded that she did not notify her that the assignments were deficient until October 20, 2009 through another "We Need" letter. She stated that the delay was likely due to being overloaded with cases. She testified that she received the final version of the AGLA assignment forms signed on 10/20/09 (Exhibit C of Appellant's Pre-Hearing Brief) on October 28, 2009. Ms. Hovington stated that despite these forms being executed, they were considered solely as requests to assign the insurance policies and not verification that they were actually assigned. She stated that this is why DMMA requested additional verification from AGLA in its October 20, 2009 "We Need" letter that the insurance policies were actually assigned. Ms. Hovington stated that she has learned through training that only the insurance company holding the policies can execute an assignment, and since these documents were only signed and completed by Ms. Miller and Pippin Funeral Home, they did not confirm the assignment.

Ms. Hovington testified that in a case like Ms. Bowen when two (2) applications are received as has been described, the July 24, 2009 application would be the primary application because it is on the correct long-term care form and is completed. However, the April 19, 2009 would be considered for purposes of preserving a filing date. Ms. Hovington did note that in this

case a filing date would not have helped the applicant because she was over resourced from April 2009 onward and would therefore not be eligible for retroactive coverage anyway.

III. Findings of Fact.

The factual findings of an administrative officer must "be supported by substantial evidence on the record as a whole." *See* 31 *Del. C.* § 520. *Dean v. Delaware Dept. of Health and Soc. Serv.,* 2000 Del. Super. LEXIS 490, *aff'd sub. nom*. 781 A.2d 693; 2001 Del. LEXIS 205 (Del. 2001). Substantial evidence is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Morales v. Apfel,* 225 F.3d 310, 316 (3d Cir. 2000*)* (quoting *Plummer v. Apfel,* 186 F.3d 422, 422 (3d Cir. 1999*)).*

Appellant, Redacted, has been a resident of long-term care facility Westminster Village in Dover, Delaware, since January 2008. An incomplete application was faxed to DMMA by Valerie Fischel, Credit and Collections Coordinator for Presbyterian Senior Living (Westminster Village), on Redacted's behalf on April 17, 2009, for unpaid nursing care bills from February 2008 through April 2009 in the amount of $95,760.17. The only information completed on the application was Ms. Bowen's name, address, date and place of birth, SSN, telephone number, and immigration status (see Exhibit A to Appellant's Pre-Hearing Brief). DMMA claims it took no action on this application because the application did not indicate what type of benefits the applicant was applying for and was mostly blank. There is speculation that the reason this initial application was not forwarded for processing by a DHSS social service technician was because it did not indicate what the applicant was applying for. There has since been training of long term care facility staff on the correct form and manner of completing Medicaid applications.

A subsequent application was filed by Redacted, Guardian of Redacted's property, on July 29, 2009 at the request of Presbyterian Senior Living (Westminster Village). Ms. Bowen's

application was denied by DMMA every month from July 2009 through November 2009 for being over resourced (see Exhibit G to Appellant's Pre-Hearing Brief). There were several issues holding up Ms. Bowen's approval per DMMA's "We Need" letters including spending down her Citizens Bank account to below the resource limit of $2,000.00. However the primary focus of the Fair Hearing was the cash surrender value of five (5) of Ms. Bowen's AGLA life insurance policies she owned which had accrued to a cash value of approximately $4,750.00 and were causing her to exceed the resource limit.

Redacted worked diligently with AGLA and DMMA to comply with each of their policies regarding assignment of these insurance policies to Pippin Funeral Home in order to pay for Ms. Bowen's funeral and to qualify her for Medicaid. On August 4, 2009, Ms. Miller first attempted to assign Ms. Bowen's life insurance policies to Pippin Funeral Home utilizing AGLA's Absolute Assignment of Life Insurance Policy form found on its AGLA's website (see Exhibit C to Appellant's Pre-Hearing Brief). Because these forms were unsatisfactorily completed by AGLA standards, it took Ms. Miller three (3) tries to execute them correctly per AGLA's request and the final copy of these completed assignment forms were signed on October 22, 2009 (see Exhibit C to Appellant's Pre-Hearing Brief).

Ms. Miller received the first "We Need" letter from DMMA on August 27, 2009 requesting, among other things, verification of the face value of Ms. Bowen's life insurance policy #803445136 as opposed to its cash surrender value; verification of the burial reserve account and the goods and services provided which should be equal to each other; and to reduce Ms. Bowen's account balance to below the $2,000.00 resource limit (see Exhibit A to Exhibit F of Appellant's Pre-Hearing Brief). Ms. Miller responded to DMMA with the information she had at the time on September 22, 2009 (see Exhibit B to Exhibit F of Appellant's Pre-Hearing Brief).

During this notification is when Ms. Miller first provided copies of the initial AGLA assignment forms she had completed to DMMA. The final version of these AGLA assignment forms, signed on 10/20/09 as shown in Exhibit C of Appellant's Pre-Hearing Brief, were not received by DMMA until October 28, 2009.

On October 20, 2009, DMMA issued a letter to Ms. Miller advising that the assignment forms she completed were not acceptable for DMMA purposes and that it would need proof from AGLA that the death benefits had been assigned (see Exhibit D to Appellant's Pre-Hearing Brief). This was because the AGLA form found online is considered a request to assign the insurance policies and the form by itself did not actually assign the insurance policies to Pippin Funeral Home. Ms. Miller attempted for several weeks to acquire such documentation from AGLA; however, in the end, AGLA advised her that she would need a court order indicating that she has the authority to assign the insurance benefits for them to be effective.

Ms. Miller then filed an Emergency Petition to Irrevocably Assign Life Insurance Policies to Funeral Home to Enable Redacted to Receive Medicaid (see Exhibit F in Appellant's Pre-Hearing Brief) on November 4, 2009 and the Petition was approved by Chancery Court and a court order issued the same day. AGLA then faxed verification of the assignments to Ms. Miller on November 12, 2009 who then faxed copies to DMMA the same day (see *Exhibit #4*).

Ms. Miller made a payment to Westminster Village in the amount of $3,500.00 around December 11, 2009 pursuant to DMMA's request in order to spend down Ms. Bowen's account to below the resource limit and Ms. Bowen was thereafter finally approved for Medicaid effective December 1, 2009 (see *Exhibit #2*).

V. Positions of the Parties

First, the Appellant maintains that she has been prejudiced due to the failure of DMMA to process the initial application filed on her behalf by Valerie Fischel of Westminster Village on April 17, 2009 (Exhibit A in Appellant's Pre-Hearing Brief) despite the fact that the second application filed by Redacted on July 29, 2009 was acted upon by DMMA. The Appellant asserts that although this application was incomplete, DMMA has processed similar limited applications in the past and at it has never acted upon this application. Because of this, the Appellant believes that this application should be automatically approved and retroactive Medicaid granted (see Argument A in Appellant's Pre-Hearing Brief).

Secondly, the Appellant argues that the AGLA life insurance policies should not be counted as a resource because they were, at times material hereto, "unavailable" to both Redacted and her guardian, Redacted. The Appellant asserts that the unavailability of this resource was largely based on Ms. Miller's continuous arduous attempts to comply with AGLA's and DMMA's requirements regarding assignment of insurance policies. She contends that because Redacted was unable to liquidate the insurance policies without a court order, the funds were effectively unavailable and should not be counted as a resource.

The State maintains that the main issue in this case is the insurance policies that continually pushed Ms. Bowen's asset level to exceed the $2,000.00 resource limit. The State acknowledges that Ms. Miller worked diligently to execute and provide the necessary documentation required and it is also aware that Ms. Miller ultimately needed a court order in order to irrevocably assign the death benefits to Pippin Funeral Home. However, the reason Ms. Bowen was not approved until December 2009 was because her accounts had not been spent down below the resource limit and there were several other outstanding issues even in November 2009 that needed to be resolved before Ms. Bowen could be deemed eligible. It contends that any

potential delay by DMMA in advising Ms. Miller what she needed to do in reference to the insurance policies, was not the cause of Ms. Bowen not being approved until December 2009.

In reference to Westminster Village's April 19, 2009 application, the State counters that if the contents of the application are actually looked at (see Exhibit A in Appellant's Pre-Hearing Brief), page 2 does not indicate what the Appellant was even applying for and the remainder of the application consisted of a thick stack of mostly unanswered questions. The State argues that only a minimal amount of information was given on the application and it was not enough for DMMA to take any action on without the subsequent July 29, 2009 application. The State asserts that even if this stack of papers qualifies as an application, this application was subsumed into the July 29, 2010 proper application that was later filed by Ms. Miller at Westminster Village's request and which was processed by DMMA.

The State's position is that it made the correct denial determination that the insurance policies were a resource until they were properly assigned and Ms. Bowen accounts were spent down, which did not occur until December 2009, when Ms. Bowen was approved.

V. Applicable Law

The mandate of the hearing officer with respect to Medicaid statutes and regulations is to "apply the State rules except to the extent they are in conflict with applicable federal regulations." 16 *DSSM* § 5406.1(1). "[T]he decision of the hearing officer [must be] supported by substantial evidence and [be] free of legal error." *Brooks v. Meconi*, 2004 Del. Super. Lexis 363, *3 (Del. Super. Ct. 2004).

Applications for benefits cannot be processed until applicants submit a completed application. The primary responsibility for establishing eligibility resides with the client. *DSSM 2000*

The filing date of an application is the date the Medicaid application is received by DMMA. *Id*. The application filing date determines the earliest date Medicaid can be effective assuming the applicant meets all factors of eligibility. *Id*. A 45-day application processing time standard begins on the date of receipt of the application. *DSSM § 16200.1* In all cases however, Medicaid is held to the 90-day timeliness standard except in unusual circumstances. *DSSM § 20103.1.3* It is the applicant or representative's responsibility to obtain the documentation needed to determine the applicant's eligibility for Medicaid. *DSSM § 20103.2* If the information is not received by the given deadline date, the application will be denied. *DSSM § 20103.1.3*

All documentation needed for the worker to determine Medicaid eligibility must be received by the due date indicated or the application will be denied. *DSSM § 20103.1.2* In cases where verification is incomplete, applicants have 15 days to return the information. *Id*. The Medicaid worker will automatically give all applicants an extension of 15 days, if needed. *DSSM § 20103.1.3* At the request of the applicant, a second extension of 15 days may be granted and a further extension may be granted in cases with unusual circumstances with supervisory approval. *Id.* In all cases however, Medicaid is held to the 90-day timeliness standard except in unusual circumstances. *Id.* It is the applicant or representative's responsibility to obtain the documentation needed to determine the applicant's eligibility for Medicaid. *DSSM § 20103.2* If the information is not received by the given deadline date, the application will be denied. *DSSM § 20103.1.3*

Effective 1/1/89, the resource limit for an individual applying for Medicaid is $2,000.00. *DSSM § 20300* Non-liquid resources are resources that require more than 20 working days to convert to cash an include annuities, household goods, vehicles, machinery and livestock, and buildings and land. *DSSM § 20300.2*

If the individual has the right, authority or power to liquidate the property, or his or her share of property, it is considered a resource. *DSSM § 20300.3* In order to be considered a resource, the individual must have a) some form of ownership interest in the property; b) a legal right to access the property; and c) the legal ability to use the property for his/her own support and maintenance. *Id*. Resources that are in effect on the first moment of the first day of a calendar month are considered as available for the entire month. *DSSM § 20300*

An individual is considered to have free access to and unrestricted use of property even when he can take those actions only through an agent. *DSSM § 20300.3.1* An agent is anyone acting in a fiduciary capacity, whether formal or informal, and regardless of the title (representative payee, conservator, guardian, etc.). *Id.* It is not required that an individual undertake litigation in order to gain access and acquiring guardianship in order to access a bank account is a petition to the court as opposed to litigation. *Id*. An account is considered a countable resource while guardianship access to the account is pending. *Id.*

Any individual who applied for Medicaid may also be eligible for Medicaid coverage of any unpaid medical bills incurred in any of the three months prior to the month in which they applied. *DSSM § 20370*

VI. Conclusions of Law

Preliminarily, it must be noted that going forward, per Delaware law, it would be more appropriate for Redacted, as Redacted's Appointed Guardian of Property, to pursue benefits on Redacted's behalf and not Presbyterian Senior Living/Westminster Village. Relevant statues and case law dictates that provider facilities are neither an applicant nor a recipient and have no right to appeal an administrative decision denying Medicaid benefits. 42 C.F.R. § 431.220(a)(1) & (a)(2) and *IFIDA v. Division of Social Services,* WL 632828 (Del. Supr. 1994). Allowing

provider facilities to represent applicants was not the intention of 42 C.F.R. § 431.206(b)(3). The only reason Westminster Village's previous pursuit of benefits on Redacted's behalf was tolerated was because there was no one else to represent Ms. Bowen and a guardian had not been appointed yet. Westminster Village had an Authorization Statement executed by Ms. Bowen's previously appointed POA authorizing Westminster to act on Ms. Bowen's behalf under the doctrine of agency.

Since Ms. Miller was assigned as Guardian of Ms. Bowen's property on May 15, 2009, this dynamic has changed and it is more appropriate that Ms. Miller pursue and appeal (if necessary) benefit applications on Ms. Bowen's behalf and it is inappropriate for Westminster Village to continue to do so. This is also evidenced by the fact that the Final Order Appointing Ms. Miller as Guardian terminated the POA executed by Ms. Bowen on May 8, 2008 naming Richard Stevenson and Pearl Stevenson as her attorneys-in fact. This is the document that gave efficacy to Mr. Stevenson's Authorization Statement giving Westminster Village the authority to pursue benefits on behalf of Ms. Bowen (see #1 of Final Order attached hereto as *Exhibit #1*).

Westminster's representation in this case is cured by the fact that her Guardian of Property, Redacted, filed the application that was processed by DMMA and she has played the main role in pursuing benefits and working with DMMA to achieve eligibility for Ms. Bowen. Otherwise, Westminster Village's standing to pursue benefits on Ms. Bowen's behalf would not likely survive a challenge.

Accordingly, the Authorization Statement signed and completed by Redacted assigning her authority to Presbyterian Senior Living d/b/a Westminster Village to take any actions required to secure Medicaid benefits on Redacted's behalf, including establishing her eligibility and filing necessary appeals, included as part of the Fair Hearing Summary of this case, is

therefore ineffective and is null and void. Even though Ms. Bowen's original POA's similar assignment to Westminster Village was considered valid under agency law, this was only so under the limited facts and circumstances of that time and should not be interpreted as a way to circumvent settled Delaware law by just having individuals with the authority assign their authority to provider facilities through an authorization statement.

Now, addressing the merits of this case, the issue is whether DMMA properly declined the Appellant from July 2009 through November 2009 for Long Term Care Medicaid for being over resourced as a result of insurance policies that were in the process of being assigned to a funeral home, but were still counted as resources by DMMA which caused the Appellant to exceed the $2,000.00 resource limit.

A. April 19, 2009 Application

The Appellant first argues that she should be automatically approved and retroactive benefits granted as a result of the untimely processing of her April 19, 2009[2] application. First, it must be noted that there is has not been any meritorious basis asserted by Westminster Village in support for "automatically" approving the Appellant's application. Even if DMMA was deemed erroneous for its failure not to process this application, the application would still of had to go through the standard verification procedures. There is no such thing as an "automatically" approved Long Term Care application.

Before there is any discussion regarding retroactive benefits, it must be first determined whether there was a valid application and if so, whether there was any undue delay in its processing. Per Ms. Hovington's testimony, she did not see the April 19, 2009 application until it

[2] Appellant references this application as the April 17, 2009 application because this is the date it was signed; however, since it was not date stamped received by DMMA until April 19, 2009, this is the date that will be used in this decision. In either case, the dates reference the same application.

was attached to the July 29, 2009 application forwarded to her[3]. Because we do not have the testimony of the technician who initially withheld the April 19, 2009 application, and then kept it long enough to attach to the subsequent application, nor any evidence as to the reasoning behind these action, it cannot be known whether or not the technician followed procedure.

The Appellant argues that other similar limited applications have been processed and approved by DMMA. Even if this is the case, the facts and circumstances of each case would have to be scrutinized to determine if it is similar or distinguishable from this case. Although the Appellant did not have such detailed information, I would be remise to look at it even if she had since every case has a different set of circumstances and this would not be the best, efficient, or practical manner deciding this case. This case like all cases should be based on the merits and not necessarily what DMMA did in other cases.

DMMA responds that the reason this application was not process is because in addition to being on the wrong form, the form that was submitted did not indicate what the applicant was applying for (see page 2 of Exhibit A to Appellant's Pre-Hearing Brief). Section § 2000 of the DSSM states that, "Applications for benefits cannot be processed until applicants submit a *completed* application" (emphasis added). The April 19, 2009 application could hardly be considered completed DHSS staff would have to guess as to what program the application was being filed for and largely base it on the attachments to the application consisting of Ms. Bowen's Long Term Care Admission Agreement and Westminster Village's Billing Statements. Even if DMMA was not as diligent as it could have been in following up with this application, per this same section, "the primary responsibility for establishing eligibility resides with the

[3] The Motion to Dismiss decision allowing Westminster Village to pursue Medicaid benefits on behalf of Redacted was not issued until around July 14, 2009. Therefore, in fairness to DMMA, it was not technically in a position to process Westminster Village's April 17, 2009 application until that time.

client." Therefore, the primary responsibility in figuring out what happened to this application was on Ms. Fischel, not DMMA.

Under these circumstances and the applicable rules regarding application requirements, the April 19, 2009 application cannot be considered a distinct application worthy of a separate DMMA decision apart from the subsequently submitted and appropriately completed July 29, 2009 application. DMMA has not "unilaterally decide[d] to hold [the Appellant's] application for over the ninety (90) day time limit" or "left the application pending for over a year" as the Appellant asserts on page 5 of the Appellant's Pre-Hearing Brief. The April 19, 2009 application was not a validly "completed" application and therefore, any undue delay arguments by the Appellant as to this application are moot.

As Ms. Hovington testified, even if the April 19, 2009 application was considered for purposes of preserving a filing date, Ms. Bowen would still not eligible for retroactive coverage because she was over resourced from April 2009 onward, until December 15, 2009. Ms. Bowen would only qualify to receive retroactive coverage during the time period she was eligible to receive long-term Medicaid, not before. Ms. Bowen was over-resourced until the $3,500.00 check was made to Westminster Village and the AGLA insurance policies were acceptably assigned. Per the evidence, both of these were not completed until December 2009 and therefore, Ms. Bowen was not eligible for coverage prior to this time.

B. "Unavailability" of American General Insurance Policies

The second and main argument of the Appellant is that the AGLA insurance policies, which caused the denial of the Appellant's application, should not be counted as resources because they were at all times materially unavailable to her and Ms. Miller. While the Appellant correctly recites DSSM § 20300 and § 20300.3 regarding the definition of a resource and what

elements must be present in order for the asset to be considered a resource to the individual (see '*Applicable Law*' section above), its argument that Ms. Bowen had no legal right, authority or power to liquidate her insurance policies until Chancery Court's November 4, 2009 Order, mischaracterizes Delaware law. The contention that Ms. Bowen's assets were not available to her because she had to rely on the cooperation of an insurance company and work through a guardian is contrary to existing law. DSSM § 20300.3.1 directly addresses these situations and decrees the following:

> An individual is considered to have free access to and unrestricted use of property even when he can take those actions only through an agent. An agent is anyone acting in a fiduciary capacity, whether formal or informal, and regardless of the title (representative payee, conservator, guardian, etc.). An account is considered a countable resource while guardianship access to the account is pending.

Without question, per DSSM § 20300.3.1, the fact that Ms. Bowen's resources were being handled by Mrs. Miller does not make the actions any less valid. This section goes on to address situations, as in this case, where liquidating an asset causes delay or when granting access to an asset to a guardian is pended. Despite American General making it an arduous task for Ms. Miller to gain access to the insurance policies, while a guardian's access to an account is pending, the account is still considered a countable resource. In addition, as cited by DMMA, "[the State] is justified to request and receive verification of [financial matters] in order to reach its eligibility determinations," and "for good reason, …eligibility requirements and necessary deadlines need to be established and followed." *Schmidt v. Meconi*, 2007 W.L. 3105750 (Del. Super).

The Appellant also goes to great lengths to argue whether the insurance policies were "actually available" to Ms. Miller. To do this however, the Appellant misconstrues the definition of "availability" as it is applied to resources for purposes of Medicaid applications. In spite of

the Appellant's attempts to make this term the test for determining countable resources, the term "actually available" is not used in any of the DSSM sections regarding resources. This test is utilized in the North Carolina Administrative Code as cited in Appellant's cited case, *Haynes v. Dept. of Human Resources*, 470 S.E.2d 56 (NC Ct. App. 1996) and is not applicable here. The test used in Delaware is an evaluation of whether the "individual has the right, authority or power to liquidate the property…," "even when those actions can only be taken through an agent." *DSSM § 20300.3, § 20300.3.1*

Moreover, the cases the Appellant cites in support for her position that availability is largely a fact-specific inquiry, are not pertinent and are distinguishable from this case. For example, in Appellant's cited case *Radon v. Blum* (89 A.D.2 858, NY App. Div. 1982), concerned a rebuttable presumption in regard to ownership of funds in a joint certificate of deposit account. This is significantly different from a situation as this where the Appellant has a Guardian of Property and is the sole owner of the subject insurance policies. In addition, cited Connecticut case *Evans v. Dept. of Social Services* is even more inconsequential with the Appellant suggesting that Mrs. Bowen being adjudicated incapacitated with an appointed guardian, is equivalent to the an applicant being in a medically induced coma during the time of the application filing (838 A.2d 250, 252; see page 7 of Appellant's Pre-Hearing Brief). The important distinction again is that Ms. Bowen's guardian, Redacted, filed a Medicaid application on Ms. Bowen's behalf and was involved during the entire application process.

The Appellant has not presented persuasive reasons or meritorious legal arguments for considering the AGLA insurance policies as "unavailable" counter to existing law. Therefore, the AGLA insurance policies in question were validly still considered countable assets for

purposes of Medicaid long-term care eligibility prior to their effective assignment to Pippin Funeral Home.

C. Assignment of AGLA Insurance Policies to Pippin Funeral Home

This determination leads the analysis into another aspect of the Appellant's line of reasoning regarding assignment of the AGLA surrender value to Pippin Funeral Home. During the Fair Hearing, Ms. Miller testified on a few occasions that she believed she provided DMMA with the initial AGLA assignment forms in August 2009. One of the Appellant's main arguments in promotion of granting Ms. Bowen retroactive coverage is that DMMA did not advise Ms. Miller that these forms were insufficient until October 20, 2009 when they were supposedly provided to DMMA sometime in August 2009. However, the actual assignment forms paint an importantly different version of events.

Ms. Miller testified that she had to complete and return the forms three (3) times before they were to AGLA's satisfaction and the forms themselves have signature dates of 10/20/09 and 10/22/09 (see Exhibit C to Appellant's Pre-Hearing Brief). Ms. Miller later testified that she provided DMMA with these forms in response to its August 2009 "We Need" letter. This "We Need" letter was not issued until August 27, 2009 and the documentary evidence provided shows that the first time DMMA was provided with copies of the AGLA forms was September 22, 2009. The executed copies were not provided to DMMA until October 28, 2009.

What I believe Ms. Miller provided to DMMA in August 2009, was the initial burial plan Ms. Miller entered into with Pippin Funeral Home (see *Exhibit #3*). Although *Exhibit #3* is a copy of the later corrected burial plan from November 2009, the initial plan indicating a $6,000.00 total for services was what was provided to DMMA in August 2009. The unequal amount between the pre-paid burial plan and the surrender value of the insurance policies is what

prompted DMMA to request that the figure be corrected to equate to each other per item #5 of its August 27, 2009 "We Need" letter (see Exhibit A to Exhibit F of Appellant's Pre-Hearing Brief).

Now, redirecting the analysis back to the AGLA policy assignments, contrary to the Appellant's contention, the AGLA forms were not an indication of when the insurance policies were assigned. As explained during the Fair Hearing, these documents were merely request forms completed by the assignor and assignee. Like Ms. Hovington surmised, some type of verification or acknowledgment from the insurance company would be needed in order to verify that the request had been accepted and executed since the forms themselves have little value if not acknowledged by the insurance company. Therefore, regardless of when the AGLA forms were provided to DMMA, the assignment was not effective until November 11, 2009.

The Appellant has presented her case as if these outstanding insurance policies Ms. Miller had worked so hard at assigning was the only thing holding Ms. Bowen back from being approved. Yet, despite almost a month in delay by DMMA in advising Ms. Miller that these forms were insufficient (from the initial submission date of September 22, 2009 to the October 20, 2009 "We Need" letter advising so as seen in Exhibit D to Appellant's Pre-Hearing Brief), the absence of this delay would not have made Ms. Bowen eligible any sooner because her Citizens Bank account was over the resource limit during this time (see *Exhibit #2*). While the insurance policies were likely the most complicated to deal with; they were not the sole reason Ms. Bowen was not approved until December 2009. DMMA's August 27, 2009 "We Need" letter specifically requested to have Ms. Bowen's resource limit reduced to below the $2,000.00 limit (see #6 of Exhibit A to Exhibit F of Appellant's Pre-Hearing Brief). It was not until Ms. Miller made a $3,500.00 payment to Westminster Village on December 11, 2009 (DMMA

received notice on December 14, 2009), which spent down her account enough to be eligible as of December 15, 2009.

D. Counting AGLA Insurance Policies as Resources Not Discriminatory

Lastly, the Appellant argues that a determination that the insurance policies were a resource to Ms. Bowen at the time of her application is discriminatory and violates the protections afforded to disabled individuals under Delaware law. Again, what the Appellant continues to ignore, which makes a marked and distinguishable difference, is the fact that Ms. Bowen was validly and legally represented by her more than capable guardian Redacted as of May 15, 2009 (see *Exhibit #1*). It is true that an incompetent person does not have the legal capacity to file or otherwise compromise any action in law or in equity in a Delaware Court under 10 Del. C. § 3923; however, Ms. Bowen did not apply for benefits for herself by her own hand; her more than capable and seasoned guardian Redacted completed the application and continued the process for her.

The Appellant also asserts that the requirements of the Medicaid process, as a matter of due process and fairness, should only be applied to Ms. Bowen beginning with the time her inability to access her funds or comply with the requirements of the Medicaid process were removed. I agree. Ms. Bowen's inability to access her funds or comply with the requirements of the Medicaid process was removed when Ms. Miller was assigned as her guardian on May 15, 2009. Ms. Bowen, through her agent, therefore, was never unable to access her funds during the processing of her application.

Contrary to the Appellant's comparison on page 10 of its Pre-Hearing Brief, Ms. Bowen is not like "an incompetent party to a lawsuit" and she did not "lack legal represent[ation]." Ms. Bowen was not discriminated against because of her disability in any way by DMMA and was

duly represented during the entire application process. Therefore, the Appellant's arguments as to Ms. Bowen incapacity during the time of application as reasoning to disregard her insurance policies as resources, are without merit since Ms. Miller, a Ms. Bowen's guardian, applied and completed the application process on Ms. Bowen's behalf.

E. Conclusion

In conclusion, since the delay by DMMA in advising Ms. Miller that the AGLA assignment forms she provided were insufficient, would not have made Ms. Bowen eligible for Medicaid any earlier, and because any delay or pending circumstances by third parties in liquidating resources does not make the resource "unavailable," but still countable per DSSM § 20300.3.1, I find that the Divisions decisions to deny Ms. Bowen for Long Term Care benefits from July 2009 through November 2009 for being over resourced, were justified. The cash value of the insurance policies were not "unavailable" simply because they were tied up in the cumbersome and lengthy process of being assigned by an agent.

WHEREFORE, the decisions of the Division of Medicaid and Medical Assistance are **AFFIRMED,** consistent with this opinion.

Date: August 5, 2010

/s/ Maria C. Tedeman-Poliquin
MARIA C. TEDEMAN-POLIQUIN
HEARING OFFICER

THE FOREGOING IS THE FINAL DECISION OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

August 5, 2010
POSTED

cc: Nicole Kearns, Redacted's Pro-hac Vice Attorney, *Appellant*
Margaret F. England, Delaware Attorney Sponsoring Nicole Kearns, *Appellant*
Redacted, Guardian of Redacted's Property
Peter Feliceangeli, DAG, Attorney for DMMA, *Appellee*

FAIR HEARING EXHIBITS

Exhibit #1 - (5 pages) Final Order from Chancery Court appointing Redacted Ms. Bowen's Guardian of Property as of May 15, 2009 and terminating the POA signed by Ms. Bowen

on May 8, 2008 appointing Richard Stevenson and Pearl Stevenson her attorneys-in-fact.

Exhibit #2 – (4 pages) Redacted's Citizens Bank Guardianship Account statements from September 2009 through December 2009 and a copy of a letter sent to DMMA giving notice of a $3,500.00 payment made to Westminster Village in order to spend down Ms. Bowen's account.

Exhibit #3 – (2 pages) Final burial plan entered into by Redacted as Guardian of Redacted's property and Pippin Funeral Home for prepaid burial services which equated to the total cash surrender value of the AGLA insurance policies.

Exhibit #4 – (10 pages) Faxed verification from AGLA that Redacted's insurance policies (total of 5) have been assigned to Pippin Funeral Home, Inc. effective November 11, 2009.