	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.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

In re: DCIS No. 0000000000

Ms. Smith, Appellant

Appearances: Ms. Jones, pro se, Appellant's Daughter and Durable Power of Attorney for Ms. Smith

Lynette Whealton, Sr. Social Worker Supervisor, Long Term Care Medicaid, Team 920
D'Lynn Duvall, Sr. Social Worker/Case Manager, Long Term Care Medicaid, Team 920

I.

Ms. Smith ("Appellant"), by and through Ms. Jones, her daughter and holder of her Durable Legal and Medical Power of Attorney, applied for Medicaid Long Term Care ("LTC") and was denied because her non-needs based income was over the $1,685.00 limit. The Appellant asserts that the Division of Medicaid and Medical Assistance ("DMMA") did not provide information in a timely manner that prevented the Appellant's daughter from expeditiously setting up a Miller Trust to exclude her mother's income.

The Division of Medicaid and Medical Assistance ("DMMA") contends that the Appellant's income limit was exceeded and therefore, her claim for Medicaid Long Term Care remained denied because her resources remained above the $1,685.00 limit until October 1, 2010.

II.

The Appellant applied for Medicaid Long Term Care on June 23, 2010.

By notice dated November 30, 2010, DMMA apparently denied the Appellant's application for Medicaid Long Term Care for the period of June 1, 2010 through September 30, 2010. (Exhibit 3)

On January 6, 2011, the Appellant filed a timely request for a fair hearing. (Exhibit 2)

The Appellant was notified by certified letter dated May 23, 2011, that a fair hearing would be held on June 6, 2011. A continuance was granted on June 22, 2011. The Appellant was notified by certified letter dated July 5, 2011, that a fair hearing would be held on July 21, 2011. The hearing was conducted on that date in Georgetown, Delaware.

This is the decision resulting from that hearing.

III.

Ms. Smith, by and through her daughter, Ms. Jones, applied for Medicaid Long Term Care ("LTC") on June 23, 2010. DMMA testified that at the time of application, the Appellant was residing at Life Care at Lofland Park ("Lofland Park"). DMMA testified that the Appellant was admitted to that facility on May 29, 2010. DMMA further testified that at the time of application for Medicaid LTC, the Appellant was not eligible: She needed a Miller Trust due to her income being over the income limit of $1,685.00.

DMMA testified that a Miller Trust is a legal document that dictates the usage of a bank account fund, including its deposits and expenditures. DMMA testified that a Miller Trust becomes necessary when a client's income exceeds the income limit, which at that time was $1,685.00.[1]

DMMA testified that at the time of application, the Appellant's gross income amounted to $1,744.95: $1,297.40 in monthly Social Security (Title II) benefits and $447.00 in monthly long-term disability benefits from Walmart ($1,297.00 + $447.00 = $1,744.40). After subtracting a standard deduction of $20.00, the Appellant's countable net income amounted to $1,724.40 ($1,744.40 - $20.00 = $1,724.40). This amount exceeded the income limit for a household of one (1), or $1,685.00.

DMMA testified that during the application interview on June 23, 2010, Ms. Jones was verbally advised that her mother's income exceeded the income limit. The DMMA worker testified that she discussed the need for a Miller Trust to resolve this issue. The DMMA worker testified that she was under the impression that Ms. Jones was unsure if she was going to bother setting up a Miller Trust: DMMA testified that it was informed by Ms. Jones that the Appellant's long term disability payments from Walmart would be ending shortly. As this payment amount was what put the Appellant's income over the limit, DMMA testified that it recommended that Ms. Jones weigh the cost of setting up a Miller Trust (estimated to be $3,000.00 to $4,000.00) against the potential uncovered medical expenses.

DMMA testified that Ms. Jones was advised that her mother would not be eligible for Long Term Medicaid until the Miller Trust was established or her income decreased below the income limit. DMMA testified that as the Miller Trust was never established, the Appellant did not become eligible for Long Term Medicaid until October 1, 2010, when her full monthly long-term disability payments from Walmart ended. (Exhibits 6 and 7) DMMA testified that prior to that date, the Appellant was over-income for Long Term Medicaid eligibility. DMMA further testified that a

[1] I note that the current income limit is set at $1,705.00.

Miller Trust cannot be established to retroactively cover the period of time that the Appellant was over-income.

Ms. Jones testified that when she applied on her mother's behalf for Medicaid Long Term Care ("LTC") on June 23, 2010, her mother was a short-term resident a Lofland Park. Ms. Jones testified that during this application interview, she was informed that her mother was over-income and would need to open a Miller Trust in order to attain eligibility for Medicaid LTC. Ms. Jones testified that while she asked the caseworker to explain how a Miller Trust worked, when she left the interview she knew no more than when she entered.[2] Ms. Jones testified that after leaving the interview, she contacted her son and daughter and asked them to research Miller Trusts for her, in order to know what she would have to do as she proceeded with the application process.[3] However, Ms. Jones testified that during the interview with the caseworker, the caseworker told her to try to avoid opening a Miller Trust in order to save money. Ms. Jones testified that she asked whether she could just have the disability payment from Walmart stopped to resolve the issue, but was told that since her mother was entitled to receive the payment, it had to be counted in her income. Ms. Jones further testified that she was informed that the best solution would be to have her mother remain a short-term resident of Lofland Park until the disability benefit ended, which would then allow eligibility for Medicaid LTC.

Ms. Jones testified that she was informed by the caseworker to proceed with her application for Medicaid LTC, but that the caseworker would not approve coverage until the disability payment ended. Ms. Jones testified that since the caseworker told her that Medicaid LTC coverage could retroactively cover one (1) month, she was under the impression that Medicaid LTC would be able to compensate for all of the time her mother spent at Lofland Park as a long-term resident.

Ms. Jones testified that following this initial interview, she received a "we need" letter dated June 23, 2010. (Exhibit 4) Ms. Jones testified that this letter did not identify the need to establish a Miller Trust in order for her mother to gain Medicaid LTC eligibility. (Exhibit 4) Ms. Jones testified that she provided the information requested on that letter to her caseworker.

Ms. Jones testified that staff at Lofland Park informed her that her mother would remain a short-term resident until the therapy she was receiving released her from care. Ms. Jones testified that on August 2, 2010, she was informed by Lofland Park that her mother would be considered a long-term care resident as of August 7, 2010. Ms. Jones testified that shortly thereafter, she left a message on her caseworker's voicemail, informing her of the change in her mother's circumstances and asking how to proceed with the application process, including the Miller Trust.

Ms. Jones testified that three (3) to four (4) weeks passed without a response from her caseworker. Ms. Jones testified that after those weeks, she was contacted by Lofland Park, inquiring as to the status of her mother's application for Medicaid LTC. Ms. Jones testified that she subsequently called and was able to speak to her DMMA caseworker that day, and was

[2] Although applicants for Medicaid LTC are to be provided with a bright yellow form concerning Miller Trusts, in this instance Ms. Jones testified that she was not given such a form.

[3] Ms. Jones testified that her daughter works at a bank, and was therefore able to question other bank workers about how a Miller Trust operates.

informed that her caseworker was still working on her application. Ms. Jones testified that she received a second "we need" letter from her caseworker on October 7, 2010, requesting more information. (Exhibit 5) Ms. Jones testified that this letter also failed to specifically identify that a Miller Trust was required in order for her mother to attain Medicaid LTC eligibility.

Ms. Jones testified that after supplying the requested information, her caseworker contacted her on October 21, 2010. Ms. Jones testified that her caseworker informed her that her mother's resources exceeded the $2,000.00 limit, and asked whether Ms. Jones had been paying her mother's bills. Ms. Jones testified that she had withheld payment on her mother's trailer, which she was attempting to sell, because she thought she was supposed to conserve her mother's resources. Ms. Jones testified that the caseworker told her to have a cashier's check written to Lofland Park in order to reduce her mother's bank account below the $2,000.00 resource limit. Ms. Jones testified that she followed those instructions.

Ms. Jones testified that upon receiving the denial notice dated November 30, 2010, she contacted her caseworker to inquire as to the reason. Ms. Jones testified that she was told that her mother was ineligible for the dates in question because she had failed to establish a Miller Trust to reduce her mother's income below the specified income limit. Ms. Jones testified that she told the caseworker that she was merely following the caseworker's instructions; in response, she testified, the caseworker explained that her suggestion to hold off on establishing the Miller Trust was due to the potential savings of such avoidance—as the disqualifying disability payment would be ending, Ms. Jones could save money by avoiding the fees associated with establishing such a trust. Ms. Jones testified that she would much rather have paid the $3,000.00 to $4,000.00 in attorney fees in order to avoid the expenses she now owes to Lofland Park for the non-covered time her mother spent as a long term resident there.

Ms. Jones testified that in all, she complied with everything she was told to do by her mother's caseworker. Ms. Jones testified that she went to the funeral home three (3) times in order to get the requested information. Ms. Jones further testified that had she been expressly told to open a Miller Trust, she would have done so. Ms. Jones testified that she entered this process without any knowledge of how it worked, and relied upon her caseworker for professional advice. As her caseworker did not directly tell her to open a Miller Trust, but discouraged her from doing so on several occasions, Ms. Jones testified that she did not feel it was fair to subsequently deny her mother's eligibility for Medicaid LTC based upon the lack of such a trust. Ms. Jones testified that she had her children research Miller Trusts, so they would know exactly what to do once she was told by her caseworker to establish such a trust.

Ms. Jones testified that when she left the initial interview on June 23, 2010, she was not provided with a standard form explaining how a Miller Trust operates. Her DMMA caseworker testified that although she did not provide such a form to Ms. Jones, she thoroughly explained Miller Trusts for quite some time.

IV.

Four issues were raised in this instance. First, whether the Appellant, through her representative, Ms. Jones, submitted the necessary documentation for the agency to make a timely determination.

Second, whether the Appellant's income is below the threshold so that she can qualify for LTC Medicaid. Third, whether the Appellant should be entitled to retroactive coverage. Fourth, whether the agency's employees have any responsibility in this matter other than gathering information, evaluating it and making a determination. I find that all of these matters must be answered in the negative.

250% Income Limit

In computing the financial eligibility of a candidate for Medicaid Long Term Care, Delaware Social Services Manual ("DSSM") 20400 allows for a trust to be set up to allow the Appellant's income to not be counted towards the monthly income limit. This trust, called a Miller Trust, made pursuant to DSSM 20400.11 - Income Trusts (Miller Trusts) is composed only of Social Security, pension, and/or other income to the individual, including accumulated interest in the trusts.

To qualify, the individual must receive the income and place it into a Miller trust. If an individual has transferred his/her right to receive the income, and the income is legally received by the trust, then this income is no longer considered to be the individual's income. In this situation the income does not meet the requirements for exemption. The trust must be composed only of income. No resources may be used to establish or add to the trust. The inclusion of resources will void the Medicaid eligibility of the trust.

Pursuant to DSSM 20100.2.2, effective January 1, 1996, two income limit standards will be applied to the LTC Acute Care Program. The 250% standard applies only to nursing facility residents. Individuals hospitalized for 30 consecutive days may be eligible only if their monthly income is 100% of the SSI standard or less. In this case, DMMA applied a 250% standard to the Appellant's income.

First, while the Medicaid application process can be confusing to someone who previously has not been involved in the process, Ms. Jones had several sources to help her understand program requirements. Testimony from both Ms. Jones and the DMMA caseworker she met with reveal that Ms. Jones was fully informed at the time of application that her mother's income exceeded the applicable limit, and that her mother would not be eligible for Medicaid LTC until her income was reduced. This testimony further establishes that Ms. Jones was advised to establish a Miller Trust in order to reduce her mother's income below the limit. I fully credit the DMMA caseworker's testimony that, as the disqualifying disability payments would be ending by October 2010, she advised Ms. Jones to weigh the costs associated with establishing such a trust against the possible expenses incurred due to Medicaid LTC ineligibility. In addition, testimony from Ms. Jones reveals that she had access to information from banking experts through her daughter. Finally, Ms. Jones could have been more diligent in calling her caseworker to discuss any issues she did not understand regarding the establishment of a Miller Trust: As DSSM 2000 identifies, it is the responsibility of the applicant to establish Medicaid LTC eligibility. Ultimately, the decision on how to go about meeting the financial requirements in order to attain Medicaid LTC eligibility

for the Appellant was Ms. Jones's. If Ms. Jones was confused about the process or what was required of her, it was incumbent upon her to ask for additional assistance.

Retroactive Coverage

Pursuant to DSSM 20370, any individual or couple 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. However, certain requirements must be met in order for these bills to be paid under Medicaid. Applications for Medicaid, even if denied, may qualify for a determination of retroactive eligibility. First, the individual must document that for time period in which the bill was incurred, all medical and financial conditions of the Long Term Care Program were met. Second, the individual must supply documentation of the unpaid bill.

In the present case, the Appellant has not established that all financial conditions of the Long Term Care Program were met for the time period when the bills were incurred. In other words, for retroactivity eligibility to apply, Ms. Jones must establish that the Appellant's income was below the 250% threshold level. The record supports that because no Miller Trust was established, the Appellant's income exceeded this limit until October 1, 2010, when her full-month disability payments from Walmart ended. Any additional change in the Long Term Care Medicaid program effective date is not supported by the record or by agency regulations.

Documentation

DSSM 20103.1.1 and 20103.1.2 provide rules outlining agency responsibilities under the Medicaid LTC application process; these responsibilities include: 1) explaining that the agency works under a 90-day time standard when determining eligibility and 2) explaining the 90-day time standard and its function with the "we need" letters. No other DMMA regulations address agency responsibilities in the application process.

Pursuant to DSSM 20103.1.3, the Medicaid worker will automatically give all applicants an extension of 15 days, if needed, using a second "We Need" letter (Form 415) to note the required documentation and the deadline date. At the request of the applicant, a second extension of 15 days may be granted using a third Form 415. With supervisory approval, a further extension may be granted in cases with unusual circumstances. Unusual circumstances include, but are not limited to, awaiting placement in a Medicaid nursing facility bed or difficulty obtaining an out-of-state deed. Medicaid is held to the 90 day timeliness standard except in unusual circumstances. If the information is not received by the given deadline date, the application will be denied.

DSSM 20103.1.3 reveals that Medicaid is held to the ninety (90) day timeliness standard except in unusual circumstances. However, DMMA would not be able to render the decision until all requested documentation had been submitted, in order to determine whether the Appellant was eligible. The submitted documentation shows that DMMA did not receive all requested information, showing that the Appellant's income had been reduced to under the income limit, until after October 1, 2010. Although the two (2) "we need" letters do not specifically state that a Miller Trust had to be established, they do support both parties' testimonies that the need for a

Miller Trust was discussed. The first "we need" letter, dated June 23, 2010, identifies that DMMA requested verification of when the disqualifying disability benefit payments would end as well as verification of application for VA benefits by the deadline of July 8, 2010. (Exhibit 4) While the submitted Explanation of Benefits from Hartford Insurance Group identifies that on July 7, 2010, DMMA received documentation showing that this disability payment would end on October 13, 2010, there is no indication that DMMA also received the requested verification of application for VA benefits. (Exhibit 7) Further, the second "we need" letter, dated October 7, 2010, shows that not only was the verification of application for VA benefits not received, but that copies of current bank statements establishing that the Appellant's disqualifying disability payments had ended were requested, to show that her income now fell below the limit. (Exhibit 5) As the Appellant failed to submit all of the requested documentation by the original deadline of July 8, 2010, the agency was precluded from meeting the ninety (90) day timeliness standard.[4]

Agency Employees

In general, DMMA employees act in a ministerial capacity. In this case, they informed the Appellant's representative about what documentation was needed for the application process, they gathered the information provided and they analyzed the information to determine whether it corresponded to the information requested in the "we need" letters. DMMA workers have no authority to act in a discretionary capacity, other than where authorized by statute.

Pursuant to DSSM 2000, under the application process the primary responsibility for establishing eligibility resides with the client, however, DMMA will take necessary action to assist the applicant to establish his eligibility for assistance. DMMA 2000 provides the following instruction for agency workers to follow to discharge their application responsibilities:

> each applicant will be informed of the programs for which he may be eligible, of his right to a decision on eligibility within a reasonable period of time, and will be informed of his right to appeal any Division decision on eligibility. Each applicant will have his need for assistance determined in accordance with Division standards. The income of an applicant will be considered in relation to his needs during the calendar month in which the individual applies for assistance. Only such resources as an applicant has currently available will be used in determining eligibility.

I find that the agency employees have acted within their authority and have processed the Appellant's application with the information provided to them by Ms. Jones.

Finally, an inquiry must be undertaken to determine whether estoppel applies. Generally, a governmental agency is not estopped by the mistaken or erroneous decisions of its officers; however, the government will be estopped if notice to appeal has not been provided. Kopicko v. State, Dept. of Services for Children, Del Super., 805 A. 2d 877, 879 (2002). The Appellant

[4] This Hearing Officer further notes that while there is a ninety (90) day timeliness standard, the regulations do not identify any consequences should the agency fail to meet this standard. As a result, this Hearing Officer is precluded from imposing any sort of penalty on the agency, should it fail to meet the ninety (90) day timeliness standard without good cause.

argued that because she relied upon her caseworker's apparently erroneous advice to hold off on establishing the Miller Trust in order to avoid the expenses associated with such a trust, that DMMA should be estopped from subsequently denying the Appellant's eligibility based upon exceeding the income limit. As noted above, a governmental agency is not estopped by the erroneous decisions of its officers. Id. Moreover, the substance of the DMMA caseworker's advice was not that of a decision; rather, it constituted advice concerning planning on how the Appellant could best be served financially. I fully credit the DMMA caseworker's testimony that as the disqualifying disability payment would be ending, she explained that it was Ms. Jones's decision whether to establish the Miller Trust immediately, with its associated fees, or shoulder the expenses related to her mother's care until that disqualifying payment ended. Submitted testimony from both the caseworker and Ms. Jones show that Ms. Jones was informed of the need to reduce income, that a Miller Trust could be used, and that the decision to establish such a trust was left to Ms. Jones. Therefore, estoppel did not prevent DMMA from proceeding to review the application and base its determination of eligibility on the Appellant's income.

I find that the agency employees have acted within their authority and have processed the Appellant's application with the information provided to them by Ms. Jones. Ms. Jones was clearly apprised that her mother's income was over the income limit due to her long-term disability payments from Walmart.

While this Hearing Officer can understand Ms. Jones's frustration with not knowing whether or how to proceed with the Miller Trust, DMMA has provided substantial credible evidence on which to sustain it's denial of Medicaid Long Term Care for the Appellant.

V.

For these reasons, the November 30, 2010 decisions of the Division of Medicaid and Medical Assistance to deny the Appellant for Medicaid Long Term Care benefits until October 1, 2010 is AFFIRMED.

Date: August 4, 2011

MICHAEL L. STEINBERG, J.D.
HEARING OFFICER

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

August 4, 2011
POSTED

cc: Ms. Jones
Lynette Whealton, DMMA, Team 920
D'Lynn Duvall, DMMA, Team 920

EXHIBITS FILED IN OR FOR THE PROCEEDING

EXHIBIT #1 - DHSS Fair Hearing Summary consisting of two (2) pages dated April 28, 2011.

EXHIBIT #2 - The Appellant's request for a fair hearing date-stamped January 6, 2011, consisting of one (1) page.

EXHIBIT #3 – Copy of a Notice to Deny Your Medical Assistance dated November 30, 2010, consisting of one (1) page.

EXHIBIT #4 – Copy of a "We Need" letter dated June 23, 2010, consisting of one (1) page.

EXHIBIT #5 –Copy of a "We Need" letter dated October 7, 2010, consisting of one (1) page.

EXHIBIT #6 – Copy of Case Notes dated October 1, 2010, consisting of one (1) page.

EXHIBIT #7 – Copy of an Explanation of Benefits from Hartford Insurance Group, dated June 28, 2010 and date-stamped July 7, 2010, consisting of three (3) pages.