STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. A-02/15-133
	)	
Appeal of	)	

INTRODUCTION

Petitioners appeal the denial of long-term care Medicaid eligibility of petitioner E.B. by the Department for Children and Families ("Department"). The following is adduced from a stipulation of facts with supporting documents and legal briefs filed by the parties.

FINDINGS OF FACT

1. Petitioner E.B. was admitted to the Franklin County Rehab Center for nursing care and was a resident there on April 23, 2014, the relevant date for the purposes of this appeal. Medicare coverage of her care at the nursing home ended as of this date.

2. On or around April 29, 2014, E.B. applied for Medicaid, but submitted an application for "community" Medicaid as opposed to "long-term care" Medicaid. E.B.'s daughter had obtained the application from the receptionist at the Department's local district office. The parties have stipulated that E.B.'s daughter explained she was in a

nursing home and was seeking Medicaid coverage for the costs of her care. Instead of an application for long-term care Medicaid, the receptionist gave the daughter a community Medicaid application.

3. The community Medicaid application does not indicate there is a separate application for long-term care coverage. The application does ask the applicant whether anyone in the household is "living outside your home in a facility that is not a school or college?" and lists "Nursing Home" by way of example. E.B.'s application answered "no" to this question.

4. E.B.'s Medicaid application was denied by the Department by notice of decision dated May 20, 2014, on the grounds that her resources were $33,088.22 above the $3,000 allowable resource limit. The resources at issue were from E.B.'s Individual Retirement Account ("IRA").

5. E.B. appealed this denial on May 27, through counsel. The letter of appeal asserts that the IRA should be excluded under the Medicaid rules as the funds were being drawn "at a rate consistent with the individual's life expectancy."

6. While the parties' stipulation does not specifically address resolution of the May 27 appeal, which

was reviewed internally by the Department, it was apparently not pursued to a Board fair hearing by the petitioners in favor of an application for long-term care Medicaid filed by E.B. on July 2, 2014. The Department's case action records indicate the following note on June 25: "[E.B.] AND [J.B.] ARE APPEALING THEIR MEDICAID DENIAL-THEY BELIEVE THEY HAD APPLIED FOR LTC[long-term care] AS [E.B.] IS IN A NURSING HOME, BUT IT WAS A 202MED. WILL FIND OUT IF THEY JUST NEED TO APPLY FOR LTC, OR IF WE FILE APPEAL".

7. The July 2 application was denied by the Department on July 3, 2014, on the grounds that the household's available resources were $728,583.82 more than the $117,240 allow resource limit. The excess resources at issue were from the IRA held by E.B. and an IRA held by her spouse, petitioner J.B.

8. Petitioners appealed the July 3 decision on July 14, through counsel. The letter of appeal asserts, as in the May 27 letter, that the IRAs should have been excluded under the Medicaid rules, as they were being drawn on "at a rate consistent with the individual's life expectancy."

9. Subsequent to the July 14 appeal, during the remainder of July and into early August, petitioners' counsel and Department workers had several contacts regarding the

denial and how to address the status of the IRAs with respect to E.B.'s eligibility.

10. On July 23, a Department worker informed petitioners' counsel that in order to be excluded resources, the IRAs were required to be fully distributed within the life expectancies established by the Social Security Administration ("SSA"). While petitioners' IRAs were issuing regular distributions at the time, the distributions were in accordance with life expectancies established by the Internal Revenue Service ("IRS"), in order to qualify as tax exempt. The resulting distributions under the IRS actuarial tables were less than what they would have been under the SSA actuarial tables, and thus under SSA standards the IRAs would not have been fully expended during the person's life expectancy.

11. Petitioner's counsel spoke with J.B. on July 23 in order to address this discrepancy with the IRAs. They contacted Wells Fargo, where the IRA accounts were held, to discuss and (as stipulated) "with the intent" of making additional distributions from each IRA which would bring the total distributions for the year in line with the SSA actuarial tables, as well as arrange for prospective monthly distributions that they believed would also be in accord with

the SSA standards. A July 23 letter from counsel to J.B. indicates that they spoke on that day (although not describing any conversation with Wells Fargo), and advises J.B. to make additional distributions from the account and arrange for higher monthly distributions.

12. The Department and petitioners' respective calculations for the appropriate distributions under the SSA standards are close to identical. The Department calculated a monthly distribution for E.B. of $251.20 and for J.B. of $6810.19. The petitioners' calculations are, in fact, slightly higher, at $258.56 per month for E.B. and $6921.01 per month for J.B.

13. As a result of discussions between petitioners' counsel and Department workers, the Department agreed to "reopen" the long-term care Medicaid application if petitioners withdrew their appeal, subject to the right to appeal any subsequent decision based on the reopened application.

14. During July, E.B.'s health began to decline and sometime at the end of July she left the nursing home and was admitted to a hospital.

15. "Snapshot" records of E.B.'s and J.B.'s IRA statements as of May 31, 2014 and July 31, 2014 were

submitted with the parties' factual stipulation. As of May 31: E.B. had drawn a total of $614.06 for the calendar year, with a draw of $142.38 during the month of May; J.B. had drawn a total of $15,000 for the calendar year, with a draw of $3,000 during the month of May. As of July 31: E.B. had drawn a total of $1,610.73 for the calendar year, with a draw of $854.29 during the month of July; J.B. had drawn a total of $21,000 for the calendar year, with a draw of $3,000 for the month of July.

16. E.B. died on August 9, 2014. At that point, no determination had been made on the reopened application. It is noted that the Department has a practice of processing Medicaid applications after the death of the applicant.

17. On August 11, 2014, Wells Fargo paid a distribution of $19,605.05 from J.B.'s IRA account. Thus, as of August 11, 2014, J.B.'s distributions totaled $39,605.05. The record does not indicate any further distributions in August.

18. On September 23, 2014, the Department issued a verification request to petitioners requesting "verification of actual dates income was received for both [E.B.] and [J.B.] in regards to their retirement accounts for May through July 2014 as we only have verification of the check sent to [J.B.] dated 8/11/14."

19. On October 6, 2014, petitioners' counsel sent a letter responding to the verification request, referring to the IRA "snapshot" statements described above, but also indicating that the August 11 distribution "was intended to cover the required distributions through July 31, 2014."

20. This response did not resolve E.B.'s eligibility, and the Department subsequently issued a notice of decision denying eligibility based on excess resources.

ORDER

The Department's decision is affirmed.

REASONS

Review of the Department's determination is de novo. The Department has the burden of proof at hearing if terminating or reducing existing benefits; otherwise the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

The substantive issue in this appeal is treatment of petitioners' IRAs – under what circumstances these funds may be excluded as a resource and when that exclusion is effective. The "spousal impoverishment provisions" of the Medicaid Catastrophic Coverage Act of 1988 ("MCCA") were enacted to protect, to an extent, the resources and income of

the non-institutionalized spouse. *See* 42 U.S.C. § 1396r-5; *Wojchowski v. Daines*, 489 F.3d 99, 102 (2nd Cir. 2007 ("The purpose of these 'spousal impoverishment provisions' was to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance.").

Medicaid rules thus provide for consideration of a "snapshot" of a married couple's available resources (whether held jointly or individually) at the time of the initial determination of eligibility. *Arkansas Dept. of Human Services v. Pierce*, 435 S.W.3d 469, 472 (Ark. 2014), *citing* 42 U.S.C. § 1396r-5(c)(1)(A). After the initial determination of eligibility, resources of the community spouse are not considered in future reviews of eligibility. *See id.;* Health Benefits Eligibility and Enrollment ("HBEE") Rules § 29.10(e)(2)(iii). Petitioners do not dispute that IRAs may be counted as an available resource, but rather at what point the IRAs in question here should have been excluded as a resource for the purposes of eligibility.

Before addressing the substantive issues presented, however, the parties each raise preliminary issues. The Department argues that this appeal should be dismissed as moot due to E.B.'s death. The petitioner raises the question

of the operative date of E.B.'s application, given that an initial application for community Medicaid was filed on April 29, followed by the long-term care application on July 2. These issues are addressed in turn.

MOOTNESS

After briefing by the parties, the Hearing Officer issued a preliminary ruling that the appeal was not moot. The Board has dismissed prior cases where the applicant had died, with no surviving spouse, heirs or assets to recover. *See* Fair Hearing No. B-12/10-69. Here, while E.B. had no probate estate, the surviving spouse has assets - among those at issue for E.B.'s Medicaid eligibility – and, as well, E.B.'s assets that were at issue for her eligibility were transferred to J.B. upon her death. Petitioners have made a showing that J.B. is subject to bona fide potential liability for the costs of E.B.'s nursing home care, including but not limited to statute of frauds claims by the nursing home for *inter vivos* transfers between E.B. and J.B.

Moreover, as one federal court has commented, "[b]ecause spouses typically possess assets and income jointly and bear financial responsibility for each other, Medicaid eligibility determinations for married applicants have resisted simple

solutions." *Houghton ex. Rel. Houghton v. Reinertson*, 382 F.3d 1162 (10th Cir. 2004) (internal citation omitted). The rules allow for consideration of the community spouse's resources at the time of application, and as such the community spouse is considered a member of the financial responsibility group at that time. *See* HBEE Rules § 29.04(c).

The purpose of the MCCA makes clear its intent to settle and/or limit potential liability of community spouses. *See Wojchowski*, *supra*. Of chief significance is the right of the community spouse to a fair hearing regarding the computation of the spousal share of resources and the attribution of such resources, *see* 42 U.S.C. § 1396r-5(e)(2), as well as "the right of the IS [institutionalized spouse] *or the CS* [community spouse] to a fair hearing *at the time of application* for MABD." HBEE Rules, § 29.10(e)(1) (emphasis added).

For these reasons, petitioners have sufficiently established J.B.'s standing to pursue this appeal and therefore receive consideration of the remaining substantive issues.

OPERATIVE APPLICATION DATE

Petitioners assert that the initial application for Medicaid, in April of 2014, should be the controlling date for the purposes of eligibility. This is based on an argument of equitable estoppel, as E.B.'s daughter was given the wrong Medicaid application by a Department worker on April 23. The Department does not dispute that petitioner was given the community Medicaid application in error, but argues that the four prongs of equitable estoppel are not met here. *See Stevens v. Dept. of Social Welfare*, 159 Vt. 408 (1992).[1] There is no apparent dispute, nor can there be, that the July 2, 2014 long-term care Medicaid application is the operative application and date, short of the April application date.

Medicaid allows for a retroactive coverage period of up to three months prior to the date of application, so long as the applicant meets the eligibility criteria during this period. *See* HBEE Rules § 70.00(b). Even assuming an application date of July 2, this would potentially allow for coverage during April, May, and June. As April 23 is the

[1] The four elements are:(1) the party to be estopped must know the facts;(2) the party to be estopped must intend that its conduct shall be acted upon or the acts must be such that the party asserting estoppel has a right to believe it is so intended;(3) the party asserting estoppel must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped. *Id.* at 421.

start date for petitioners' request for coverage, the July 2 application effectively covers the period of eligibility they seek. In this respect, there is no need to reach the equitable estoppel question, as the issue of eligibility remains the same post- and pre-application date.

TREATMENT OF THE IRA(S)

Petitioners do not dispute that the IRA of a community spouse may be counted as an available resource at the time of the initial eligibility application. *See* HBEE Rules § 29.07(b)(2)(vi). The rules, however, do allow for exclusion of retirement funds under the following circumstances:

> (i) Any retirement fund owned by a member of the financial responsibility group is excluded when:
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> (A) The member must terminate employment in order to obtain any payment from the fund;
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> (B) The member is not eligible for periodic payments from the fund and does not have the option of withdrawing a lump sum from the fund; or
>
> *(C) The member is drawing on the retirement fund at a rate consistent with their life expectancy, as specified in § 25.03(b).*
>
> (ii) If the member is eligible for periodic payments or a lump sum, *the member must choose the periodic payments.* If the member receives a denial on a claim for periodic retirement benefits, but can withdraw the funds in a lump sum, the lump sum value is counted in the resources determination for the month following that in which the member receives the denial notice.

HBEE Rules § 29.08(i)(5) (emphasis added).

As it is referred to above, rule 25.03(b) provides:

> (b) Receipt of fair market value after the date of the transfer: If the value of a transferred resource is scheduled for receipt after the date of transfer, it is considered a transfer for fair market value only if the transferor can expect to receive the full fair-market value of the resource within their expected lifetime. Expected lifetime is determined as follows:
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> (1) When institutionalized individual is transferor: Expected lifetime of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.
>
> (2) When spouse of institutionalized individual is transferor: Expected lifetime of the spouse of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA) (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.

HBEE Rules § 25.03(b).

Based on the record, the only applicable criterion for exclusion of the IRAs is when the household member is drawing at a rate consistent with life expectancy, a condition that petitioners do not dispute. *See* HBEE Rules § 29.08(i)(5)(i)(C). With respect to the applicable life expectancy standard, while petitioners suggest that perhaps there is an inconsistency given that rule 25.03(b) refers to

transfers, its reference in the rule pertaining to retirement funds (HBEE Rules § 29.08(i)(5)) is clearly intended to incorporate the life expectancy tables of the SSA as specified. In fact, petitioners attempted to conform the IRA to such expectations. And, petitioners point to nothing in the rules or law precluding the Department from utilizing the SSA actuarial tables. In fact, the federal law excluding annuities, by way of comparison, specifically utilizes the same actuarial tables published by the SSA. *See* 42 U.S.C. § 1396p(c)(G)(ii).

The parties' remaining dispute centers around the meaning of the term "periodic" and for what period the IRAs can be said to have been conformed to the SSA standards. Petitioners argue that the term "periodic" could be as long as on a "yearly" basis, and thus, as of the first seven months of the year, they had received a total of distributions in line with the SSA standards.[2] The Department argues that petitioners in effect took a one-time lump sum distribution at or around the end of a seven to eight month period which does not meet the definition of

[2] This assumes for the purposes of argument that the total distributions, in fact, met the actuarial standard, at least as of August 11, 2014. That was not the focus or basis of the Department's denial.

periodic, and that "periodic" means coming at prospective and equal intervals to sufficiently establish the IRA will be expended within the person's putative lifetime.

The Department relies on the section of the SSA Program Manual for processing SSI applications, which states that "[p]eriodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly) and which result from entitlement under a retirement fund." SSA Program Operations Manual System ("POMS") SI 01120.210. Of further note, the dictionary definition of "periodic" includes "occurring or recurring at regular intervals."[3]

In any event, the Department's interpretation is reasonable and consistent with an accepted understanding of the term "periodic." While this does not preclude "yearly" periods, the facts here do not support such periodic distributions. The final distributions as of August 11 for both E.B. and J.B. were made on an irregular, ad-hoc basis. To find that this meets the definition of the term periodic would undermine the clear purpose of the resource exclusion to provide a measure of certainty that the funds will be

[3] *See* Merriam-Webster On-line: http://www.merriam-webster.com/dictionary/periodic.

received within the person's lifetime, under the standard provided in the rules.

Moreover, the record indicates that the final transfer was made on August 11, approximately two weeks after E.B.'s discharge from the nursing home into the hospital. Without more, even under petitioners' theory, that is presumed to be the date the "resource" was converted to one that could be excluded. The rules are unambiguous that the retirement fund is excluded when the person "*is drawing*" on the fund at a rate consistent with the SSA life expectancy tables, *see* HBEE Rules § 29.08(i)(5), and that:

> An individual requesting MABD with excess resources is determined to have passed the resource test upon proof that the excess resources *are no longer held as a resource* and have actually been spent or given away.

HBEE Rules § 30.04(a)(1) (emphasis added).

The requirement of the rules is clear – that the point of eligibility (with respect to excess resources) is not necessarily the application date, but when there is no excess resource. Even if one were to accept that the ad-hoc distribution dated August 11 meets the "periodic" test, it was not effectuated until after E.B. had left the nursing home. The petitioners cannot treat that distribution in both ways; that is, cannot argue it comes within a period of time

(such as a year) that can be averaged or "spread out" over that period, but ignore the actual date it was effective within that period.[4] Thus, the earliest possible date of E.B.'s eligibility does not cover the period in which she resided in the nursing home.

As such, the Department's denial of eligibility is consistent with the applicable rules and must be affirmed. *See* 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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[4] This in fact, illustrates the Department's point that "periodic" is intended to convey predictability, which must be prospective.