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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of:	)	
	)	
[redacted],	)	OHA Case No. 10-FH-20
	)	
Claimant.	)	DPA Case No. [redacted]
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) was a recipient of Medicaid benefits prior to October 2009 (Ex. 1). On October 2, 2009 the Claimant signed an Eligibility Review Form for the Food Stamp and Medicaid Programs (Exs. 2 – 2.5). This Form was received by the Division of Public Assistance (DPA or Division) on October 2, 2009 (Ex. 2).

On October 26, 2009 the Division mailed to the Claimant a notice titled "Incomplete Medicaid Review – Info. Needed" (Ex. 4). The notice stated that the information and documentation requested needed to be returned by November 6, 2009 or the Claimant's Medicaid benefits might be reduced or terminated. *Id.*

The Division did not receive the information and documentation it had requested from the Claimant by the November 6, 2009 deadline (Ex. 5). On November 20, 2009 the Division mailed to the Claimant a notice stating that his Medicaid benefits would be terminated after November 30, 2009, for failure to provide the requested information and documentation (Exs. 6, 9). The Claimant requested a fair hearing contesting the termination of his Medicaid benefits on January 11, 2010 (Ex. 9.1).

This Office has jurisdiction to resolve this case pursuant to 7 AAC 49.010.

A hearing was held as scheduled on March 2, 2010 before Hearing Examiner Claire Steffens. The Claimant appeared by telephone, represented himself, and testified on his own behalf. DPA Public Assistance Analyst [redacted] appeared in person to represent and testify on behalf of the Division.

At this hearing the Claimant stated that he did not have the opportunity to prepare for the hearing adequately because he cannot read very well, and because the person who normally reads documents to him was in the hospital. Accordingly, the hearing was continued pursuant to the Claimant's request.

The hearing resumed as scheduled on March 16, 2010 before Hearing Examiner Patricia Huna. [1] The Claimant appeared by telephone, represented himself, and testified on his own behalf. DPA Public Assistance Analyst [redacted] appeared in person to represent and testify on behalf of the Division. [redacted], an Eligibility Technician I employed by the Division, was called as a witness by the Claimant and testified telephonically. All testimony and exhibits offered by the parties were received into evidence. At the end of the hearing the record was closed and the case was submitted for decision.

The Claimant re-applied for Medicaid benefits circa March 1, 2010 and this time submitted the information and documentation previously requested by the Division. The record is not clear as to whether the Claimant's March 1, 2010 application was approved. In any event, at the hearing of March 16, 2010 the parties stipulated that the only months for which benefits are at issue in this case are December 2009, January 2010, and February 2010.

ISSUE

Was the Division correct to terminate the Claimant's Medicaid benefits after November 30, 2009 based on the Claimant's failure to timely provide information and documentation requested by the Division for the purpose of determining the Claimant's continued Medicaid Program eligibility?

FINDINGS OF FACT

The following facts were established by a preponderance of the evidence:

1. The Claimant cannot read or write very well (Claimant hearing testimony). He usually has his sister-in-law read documents to him when she is available. *Id.*

2. Prior to October 2009 the Claimant was a recipient of Medicaid Program benefits (Ex. 1).

3. On October 2, 2009 the Claimant signed an Eligibility Review Form for the Food Stamp and Medicaid Programs (Exs. 2 – 2.5). This Form was received by the Division of Public Assistance (DPA or Division) on October 2, 2009 (Ex. 2).

4. On October 20, 2009 DPA Eligibility Technician I [redacted] had a telephonic eligibility interview with the Claimant and his authorized representative (Ex. 3, [redacted] hearing testimony).

[1] Following the hearing this case was reassigned to Hearing Examiner Jay Durych. He reviewed this Office's hardcopy file, and listened to the digital recording of both hearings held in this case, prior to preparing and issuing this Decision.

5. On October 26, 2009 the Division mailed to the Claimant a notice titled "Incomplete Medicaid Review – Info. Needed" (Ex. 4). That notice stated in relevant part as follows:

> Your Medicaid Review was received in our office on October 2, 2009. We need more information or proof. Please give us the items listed . . . by November 6, 2009 or your case may close.
>
> * * * * * * * * * * * *
>
> Information or proof needed: Provide copies of the last three months' bank statements for your trust account. You will also need to identify all withdrawals and explain what the money was spent on . . . .

6. A case note by DPA Eligibility Technician I [redacted] dated November 19, 2009 (Ex. 5) states in relevant part as follows:

> I had sent [the Claimant] a notice asking for copies of the last three months' bank statements for his trust account. Also asked him to identify all withdrawals and explain what the money was spent on. This was due back on November 6, 2009. Did not get it. Checked mail and pend rack. Closed [case] and sent client notice.

7. On November 20, 2009 the Division mailed to the Claimant a notice of termination of his Medicaid benefits for failure to provide information and/or documentation (Exs. 6, 9). That notice stated in relevant part as follows:

> Your Medicaid case is closed and you will not get benefits after November 30, 2009 because you did not give us the items or proof we requested . . . .
>
> * * * * * * * * * * * *
>
> Family Medicaid Manual Section 5000-4; Aged / Disabled / LTC Medicaid Manual Section 520-E; and APA Manual Section 400-4 support this action.
>
> Items we asked for and did not get: You did not provide copies of the last three months' bank statements for your trust account. You needed to identify all withdrawals and explain what the money was spent on. If you can provide this information prior to December 31, 2009 we can look at your Medicaid eligibility again . . . .

8. On December 28, 2009 the Division received some information and documentation pertaining to the Claimant's bank accounts and his expenses for rent and telephone service (Exs. 9.2 – 9.5, 11). However, the information and documentation received did not include all of the items that had been requested by the Division. *Id.*

9. The Claimant requested a hearing contesting the termination of his Medicaid benefits on January 11, 2010 (Ex. 9.1). His stated reason for contesting the DPA's termination of benefits was that he had "filled out and turned everything in for my Medicaid before December 31, 2009 . . ." (Ex 9.1).

10. The Claimant never advised the Division, either before or during the hearing, of any circumstances which would have constituted good cause to extend the period for providing the information and documentation requested.

11. The Claimant re-applied for Medicaid benefits circa March 1, 2010 (Claimant hearing testimony). He provided the Division with the last three (3) months of statements for his trust account at that time. *Id.* He admitted at the hearing that he had not previously provided that documentation to the Division. *Id.*

12. The record does not reflect whether the Claimant's March 1, 2010 application was approved. In any event, at the hearing of March 16, 2010 the parties stipulated that the only months for which benefits are at issue in this case are December 2009, January 2010, and February 2010.

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

This case involves a termination of previously existing Medicaid benefits. The Division therefore has the burden of proving its assertions [2] by a preponderance of the evidence. [3]

II. The Medicaid Program – In General.

Medicaid is an entitlement program created by the federal government. See DOA website at http://health.hss.state.ak.us/dpa/programs/medicaid/ (date accessed July 31, 2009). It is the primary public program for financing basic health and long-term care services for low-income Alaskans. *Id.* It is funded fifty percent by federal funds and fifty percent by State general funds. *Id.* The program focuses on coverage for low-income children, pregnant women, families, the elderly, the blind, and the permanently disabled. *Id.*

The Medicaid program is administered in Alaska by the Division of Health Care Services (DHCS). *Id.* While DHCS is responsible for program and policy development, the Division of Public Assistance (DPA) is responsible for determining the financial eligibility of individuals and families in need of Medicaid benefits. *Id.* The majority of Medicaid recipients are beneficiaries of other programs and services administered and delivered by DPA. *Id.* Almost 70,000 Alaskans receive medical benefits through the Medicaid Program. *Id.*

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[2] "Ordinarily the party seeking a change in the status quo has the burden of proof." *State of Alaska Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985). Accordingly, the Division bears the burden of proof in this case because the Division is seeking to change the existing status quo by terminating the Claimant's benefits.

[3] The "preponderance of the evidence" standard is the normal standard of proof in an administrative proceeding. *Amerada Hess Pipeline v. Alaska Public Utilities Commission*, 711 P.2d 1170, n. 14 at 1179 (Alaska 1986). Preponderance of the evidence is defined as "[e]vidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not." *Black's Law Dictionary* 1064 (West Publishing, Fifth Edition, 1979).

III. The Medicaid Program – Provisions Pertaining to Verification of Information.

State Medicaid regulation 7 AAC 100.016 provides in relevant part as follows:

> (a) The department will verify whether an applicant or recipient meets eligibility requirements.
>
> (b) The department will request in writing that an applicant or recipient provide documentation that the applicant or recipient meets eligibility requirements if the required documentation is not readily available to the department from any alternative source or the information needed cannot be verified from an alternative source readily available to the department . . . .
>
> * * * * * * * * * * * *

State Medicaid regulation 7 AAC 100.020 provides in relevant part as follows:

> (a) . . . [A]t least once every 12 months, the department will require a recipient who is eligible for Medicaid . . . to submit a review application on a form provided by the department and furnish the documentation requested by the department to support continued eligibility . . . .
>
> * * * * * * * * * * * *

State Medicaid regulation 7 AAC 100.022 provides in relevant part as follows:

> (a) A timely review application is one that is received on or before the date requested . . . . If . . . . the requested documentation is not received on or before the due date, the department will send the recipient a notice that, starting the first day of the month immediately after the date of that notice, the recipient will no longer be eligible for Medicaid.

Aged, Disabled, and Long Term Care Medicaid Eligibility Manual Section 520-E, titled "Verification And Documentation," states "[r]efer to APA Manual Section 400-4 for policy on verification . . . .

Adult Public Assistance Manual Section 400-4 states in relevant part as follows:

> 400-4 A. Requirement To Provide Necessary Verification
>
> An individual must satisfy many eligibility requirements to be determined eligible to receive Adult Public Assistance benefits. *The client must provide proof that he or she meets each factor of eligibility* . . . . [Emphasis added].

400-4 B. Informing The Client Of Requirement To Provide Necessary Verification

If a particular factor of eligibility must be verified so that a decision can be made on a client's eligibility . . . the case worker shall provide the client with a written notice that states what evidence is needed and gives a reasonable amount of time (at least 10 days) to submit the necessary proof . . . . *If the client fails, without good cause, to respond to the notice within the amount of time allowed, eligibility for assistance does not exist*. . . . [Emphasis added].

400-4 C. Failure To Provide Necessary Verification

Eligibility does not exist if an applicant or recipient fails to provide necessary verification . . . . [Emphasis added].

400-4 D. Responsibility To Provide Necessary Verification

The client is always responsible for providing whatever verification is necessary to establish his or her own eligibility for benefits . . . . [Emphasis added].

ANALYSIS

The facts relevant to this case are not disputed. The Claimant was receiving Medicaid benefits from the Division (Ex. 1). The Division scheduled a routine eligibility review pursuant to 7 AAC 100.016; 7 AAC 100.020; and 7 AAC 100.400(a). On October 2, 2009 the Claimant signed an Eligibility Review Form for the Medicaid Program (Exs. 2 – 2.5). This Form was received by the Division on October 2, 2009 (Ex. 2).

On October 26, 2009 the Division mailed to the Claimant a notice titled "Incomplete Medicaid Review – Info. Needed" (Ex. 4). That notice requested that the Claimant "provide copies of the last three months' bank statements for your trust account." *Id.* The notice also advised the Claimant that he would "also need to identify all withdrawals and explain what the money was spent on . . ." *Id.* The Claimant was warned that he needed to provide this information and documentation to the Division by November 6, 2009 or his case might be closed. *Id.* The eleven (11) day period within which the Division requested a response satisfied the applicable notice requirements. The Division was only required to provide Claimant with a reasonable amount of time (at least 10 days) to provide the information. *See* Adult Public Assistance Manual Section 400-4B; [4] Federal Medicaid regulation 42 CFR 431.211; Alaska regulation 7 AAC 49.060. [5]

[4] Section 520-E of the Aged, Disabled, and Long Term Care Medicaid Eligibility Manual, titled "Verification And Documentation," incorporates the verification policy set forth in APA Manual Section 400-4 by reference.

[5] Federal Medicaid regulation 42 CFR 431.211 requires that the Division "mail a notice at least 10 days before the date of action." Similarly, pursuant to Alaska regulation 7 AAC 49.060, the Division is generally required to "give written notice to the client at least 10 days before the date the Division intends to take action denying, suspending, reducing, or terminating assistance . . . " The notice period "is computed by excluding the first day and including the last, unless the last day is a holiday, and then it is also excluded." AS 01.10.080; *Perito v. Perito*, 756 P.2d 895, 898 (Alaska 1988).

The Division did not receive the requested information and documentation back from the Claimant by the November 6, 2009 deadline (Ex. 5). Neither did the Claimant ever advise the Division of any circumstances which would have constituted good cause to extend the period for providing the information and documentation requested (see Findings of Fact at paragraph 10, above). Accordingly, on November 20, 2009 the Division, having received no response from the Claimant, mailed to the Claimant a notice stating that his Medicaid benefits would be terminated after November 30, 2009 for failure to provide the requested information and documentation (Exs. 6, 9). The ten (10) day period which the Division gave the Claimant prior to implementation of its notice of adverse action (i.e. prior to its termination of benefits) again satisfied the applicable notice requirements (see footnote 5 at page 6, above).

It should also be noted that the Division's notice of November 20, 2009 stated that the Division could reconsider its termination of the Claimant's Medicaid benefits if the Claimant provided the requested information and documentation *by December 31, 2009* (Exs. 6, 9). Thus, the Division generously provided the Claimant with an *extra 54 days*, (from November 7 through December 31, 2009), to submit the requested information and documentation. The record shows that the Claimant failed to provide the requested information and documentation to the Division by December 31, 2009. Indeed, the Claimant himself testified that he provided the documentation to the Division *for the first time* circa March 1, 2010, when he re-applied for benefits. [6]

In summary, the Division is legally required to periodically re-verify a claimant's eligibility for Medicaid benefits pursuant to 7 AAC 100.016, 7 AAC 100.020, 7 AAC 100.022, Aged, Disabled, and Long Term Care Medicaid Eligibility Manual Section 520-E, and Adult Public Assistance Manual Section 400-4 (set forth in the Principles of Law, above). The Division attempted to do so and requested certain information and documentation from the Claimant.

The Division provided the Claimant more time than was legally required to provide the requested information and documentation (see footnote 5, above). Specifically, the Division was only required to provide Claimant with a reasonable amount of time, at least 10 days, to provide the information. However, the Division generously provided the Claimant with an *extra 54 days*, (from November 7 through December 31, 2009), to submit the requested information and documentation. In spite of this additional time, the Claimant failed to respond to the Division's request for information and documentation on a timely basis. Accordingly, the Division was correct to terminate the Claimant's Medicaid benefits because of his failure to provide the information and documentation requested, pursuant to 7 AAC 100.016, 7 AAC 100.020, 7 AAC 100.022, Aged, Disabled, and Long Term Care Medicaid Eligibility Manual Section 520-E, and Adult Public Assistance Manual Section 400-4.

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[6] As discussed above, December 31, 2009 was the last day that the Claimant's forms and information could be accepted as a reapplication (Exs. 6, 9). There was no evidence in the record indicating that the Claimant's information and documentation were received by December 31, 2009 (see Findings of Fact at Paragraphs 8 and 10, above). Rather, the record reflects that the Claimant re-applied for Medicaid benefits circa March 1, 2010, and that he did not provide the requested documentation until that time.

CONCLUSIONS OF LAW

1. The Division is required to periodically re-verify a claimant's eligibility for Medicaid benefits pursuant to 7 AAC 100.016 , 7 AAC 100.020, 7 AAC 100.022, Aged, Disabled, and Long Term Care Medicaid Eligibility Manual Section 520-E, and Adult Public Assistance Manual Section 400-4.

2. The Division carried its burden and proved, by a preponderance of the evidence, that:

   a. It requested certain information and documentation from the Claimant in order to re-verify the Claimant's eligibility for Medicaid benefits.

   b. It allowed the Claimant more time than legally required by the applicable regulations and Division policy (42 CFR 431.211, 7 AAC 49.060, Aged, Disabled, and Long Term Care Medicaid Eligibility Manual Section 520-E, and Adult Public Assistance Manual Section 400-4) to respond to the request for information and documentation.

   c. The Claimant failed to respond to the Division's request for information and documentation on a timely basis.

3. Accordingly, the Division was correct to terminate the Claimant's Medicaid benefits, after November 30, 2009, based on the Claimant's failure to timely provide information and documentation requested by the Division for the purpose of determining the Claimant's continued Medicaid Program eligibility.

DECISION

The Division was correct to terminate the Claimant's Medicaid benefits, after November 30, 2009, based on the Claimant's failure to timely provide information and documentation requested by the Division for the purpose of determining the Claimant's continued Medicaid Program eligibility.

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, the Claimant must send a written request directly to:

Director of the Division of Public Assistance
Department of Health and Social Services
PO Box 110640
Juneau, AK 99811-0640

An appeal request must be sent within 15 days from the date of receipt of this decision. Filing an appeal with the Director could result in the reversal of this decision.

DATED this 22nd day of April, 2010.

/signed/
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this 22nd day of April 2010
true and correct copies of the foregoing document
were sent to the Claimant via U.S.P.S. mail, and to
the remainder of the service list by e-mail, as follows:

Claimant – Certified Mail, Return Receipt Requested
[redacted], DPA Hearing Representative

[redacted], Director, Division of Public Assistance
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Chief of Field Services
[redacted], Administrative Assistant II
[redacted], Eligibility Technician I

J. Albert Levitre, Jr.
Law Office Assistant I