Office of Hearings and Appeals
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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. 11-FH-102
	)	
Claimant.	)	Division Case No. [redacted]

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) applied for re-certification of her Medicaid benefits on January 27, 2011. On February 7, 2011, the Division sent Claimant a notice it approved her application. (Ex. 4) This same written notice informed Claimant she would not receive Medicaid benefits for December 2010 and January 2011 because during those months she had resources in excess of the resource amount allowed for eligibility for Medicaid benefits. (Ex. 4) Claimant requested a fair hearing on February 18, 2011. (Ex. 5)

This office has jurisdiction pursuant to 7 AAC 49.010.

A hearing was held on March 31, 2011 and on April 12, 2011. Claimant attended both days of the hearing solely through her representatives, her power of attorney and sister, Ms. [redacted], and her care coordinator, Ms. [redacted].[1] Ms. [redacted] and Ms. [redacted] testified telephonically, represented Claimant and testified on her behalf. [redacted], Public Assistance Analyst with the Division, attended the hearing in person, and testified on behalf of the Division. The evidentiary record was left open until April 26, 2011 for Claimant to submit additional documents if she desired, and until May 2, 2011 for the Division to respond to Claimant's submission. No additional documents were received at any time. The evidentiary record closed on May 2, 2011. All offered exhibits were admitted.

ISSUE

On February 7, 2011, was the Division correct to deny Claimant's application for Medicaid benefits for January 2011 and for December 2010 because Claimant owned resources valued in excess of the $2,000 amount allowed for eligibility for Medicaid benefits?

[1] For all purposes of this decision, references to Claimant include references to Ms [redacted] and/or Ms. [redacted].

FINDINGS OF FACT

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

1. Claimant is a non-working 88-year-old single adult. (Ex. 2.0) She does not receive Supplemental Security Income benefits. (Ex. 2.4; Ex. 3) Claimant receives $878.00 monthly income from Social Security and $175.00 monthly from a [redacted] investment bank account. (Exs. 2.8; 9.1; 9.3)

2. Prior to November 2010, Claimant had been receiving Medicaid benefits but failed to apply to recertify her eligibility for benefits in November 2010. (Ex. 3) During the period October-November-December 2010, Claimant suffered considerable health issues, including periods of hospitalization, such that she was unable to attend to her affairs and pay her bills. (Claimant's testimony; Ex. 5.2) Claimant did not submit her recertification application until January 27, 2011 and therefore her Medicaid eligibility lapsed. (Ex. 3)

3. On January 27, 2011, Claimant submitted a recertification application. (Exs. 2.0-2.7) On her application, Claimant disclosed she owned a bank account. (Ex. 2.2) This account had a balance in excess of $2,000 at all times between October 26, 2010 and November 23, 2010. (Ex. 2.9) In addition, Claimant's bank account statements show:

November 1, 2010	Balance $2,444.61	Ex. 2.9
December 1, 2010	Balance $2,600.64	Ex. 9.2
December 30, 2010	Balance $2,522.12	Ex. 9.4
January 3, 2011	Balance $3,400.12	Ex. 2.8

4. On January 27, 2011, Claimant participated in an eligibility interview. (Ex. 3) The Eligibility Technician determined that Claimant's recertification application could be approved beginning February 2011 but that Claimant had a bank account resource valued in excess of $2,000 in both December 2010 and January 2011 and therefore did not qualify for benefits for those months. (Ex. 3)

5. The Division sent a written notice on February 7, 2011 informing Claimant her application had been approved and that she would begin receiving benefits in February 2011. (Ex. 4.2) In that same notice, the Division informed Claimant that because her bank account balance, considered a resource, exceeded $2,000 on the "first moment of the month of that month,"[2] i.e., January 2011, Claimant was not eligible for benefits for January 2011. (Ex. 4.2) This notice also informed Claimant she was not eligible for retroactive Medicaid benefits for December 2010 for the same reason. (Ex. 4.2) *See also,* Exhibit 4.

[2] This choice of words does not exactly reflect the regulation that provides an individual's resources are valued "at any time on the first day of a calendar month…."7 AAC 40.270(b). However, in this case the distinction does not matter.

6. Claimant does not dispute the Division's determinations. She asserts she should be eligible because the balance in her bank account accumulated as a result of reasons beyond her control. First, Claimant suffered health issues causing her to be repeatedly admitted to the hospital and making her unable to tend to her affairs and pay her bills. Claimant's income did not change but because her primary care provider was unable to attend to Claimant's health issues and her financial affairs simultaneously, Claimant's bills were not paid and the balance in her bank account accrued above $2,000. (Claimant's testimony)

8. Claimant testified it is a special hardship for Claimant to be denied Medicaid benefits during December 2010 and January 2011 because the agencies providing Claimant's Medicaid-paid services continued to provide them at that time but Claimant is unable to pay for those services. Claimant also testified that it seems unfair to deny benefits for December 2010 and January 2011 because Claimant qualified (financially) before December 2010 and after January 2011 and her income never changed; the only change was that Claimant did not spend her income as normal due to her emergency health circumstances. (Claimant's testimony)

PRINCIPLES OF LAW

Burden of Proof and Standard of Proof

"Ordinarily the party seeking a change in the status quo has the burden of proof." *State, Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985). The standard of proof in an administrative proceeding is a "preponderance of the evidence," unless otherwise stated. *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Com'n*, 711 P.2d 1170, 1183 (Alaska 1986) "Where one has the burden of proving asserted facts by a preponderance of the evidence, he must induce a belief in the minds of the triers of fact that the asserted facts are probably true." *Robinson v. Municipality of Anchorage*, 69 P.3d 489, 495 (Alaska 2003)

Medicaid for Older Alaskans

The State of Alaska provides medical assistance to needy persons who are eligible. AS 47.07.010; AS 47.07.020. It does this, in part, by participating in the national medical assistance program provided by 42 U.S.C. 1396 – 1396p, (Title XIX of the Social Security Act), which provides grants to states for medical assistance programs, including Medicaid. The Alaska Older Alaskans program is administered under Home and Community Based Waiver Services and is a Medicaid benefit program. 7 AAC 40.090; .120; 7 AAC 100.002; .400.

To be eligible for Medicaid benefits under the Older Alaskans Home and Community Based Waiver Services, the value of a single applicant's non-excludable resources may not exceed $2,000. 7 AAC 40. 270(a). An individual's resources are valued at any time on the first day of the calendar month. 7 AAC 40.270(b). An individual's resources are any real or personal property the individual owns and can convert to cash to be used for that person's support and maintenance. 7 AAC 40.260.

Some resources are excluded from being counted but bank accounts are not among excluded resources. 7 AAC 40.280. Resources that are not excluded from being counted are called "non-excludable" resources. 7 AAC 40.270.

"Administrative agencies are bound by their regulations just as the public is bound to them." *Burke v. Houston NANA, L.L.C.*, 222 P.3d 851(Alaska 2010).

The authority of the Office of Hearings and Appeals is limited to the scope identified in 7 AAC 49.170, that provides, in relevant part:

> Except as otherwise specified in applicable federal regulations … the role of the hearing authority is limited to the ascertainment of whether the laws, regulations, and policies have been properly applied in the case and whether the computation of the benefit amount, if in dispute, is in accordance with them.

ANALYSIS

Issue

On February 7, 2011, was the Division correct to deny Claimant's application for Medicaid benefits in January 2011 and for December 2010 because Claimant owned resources valued in excess of the $2,000 amount allowed for eligibility for Medicaid benefits?

Burden of Proof and Standard of Proof

Claimant has the burden of proof by a preponderance of the evidence because she is applying for benefits and therefore changing the status quo.

Claimant's Non-Excludable Resource Exceeded $2,000 on the First Day of December 2010 and January 2011.

Claimant is a non-working 88-year-old single adult. She does not receive Supplemental Security Income benefits. She receives monthly income from Social Security and a small additional amount through an investment bank. She owns a bank account that represents her cash resource.

To be eligible for Medicaid benefits, an individual applicant cannot have resources whose total value is $2,000 or more. An individual's resources are valued at any time on the first day of the calendar month. 7 AAC 40.270(b). The clear facts are that Claimant had funds in excess of $2,000 on the first day of December 2010. The evidence is undisputed that on December 31, 2010 and on the first business day of January 2011, i.e., January 3, in 2011, Claimant's bank account balance exceeded $2,000. Therefore, in December 2010 and January 3, 2011, Claimant did not meet the resource eligibility requirements to qualify for Medicaid.

The parties agree that Claimant had an excess of $2,000 on the first day of December 2010 and of January 2011 in her bank account. Therefore, there is no factual dispute that she did not meet

the resource eligibility limit for the Home and Community Based Waiver Services, Older Alaskans Program.

Claimant argues the fact she exceeded the resource limit in December 2010 and January 2011 should be excused because of her need and because she had extraordinary medical circumstances which prevented her from spending her income, so as to remain under the $2,000 eligibility limit. Claimant asserts that not receiving Medicaid benefits during December 2010 and January 2011 is a substantial hardship because her care givers and agencies that provide assistance to her continued to do so in those months and she is unable to pay their bills.

Claimant's arguments are understandable. However, the Medicaid program is a federal program administered pursuant to specific laws and regulations which cannot be changed or disregarded, absent legislation or rule-making. The administration of the federal Medicaid program by the State of Alaska requires the State to abide by and implement the federal laws and regulations. The Division of Public Assistance does not have the authority to create an exception to the law concerning Medicaid and is required to implement the law as it exists. "Administrative agencies are bound by their regulations just as the public is bound to them." *Burke v. Houston NANA, L.L.C.*, 222 P.3d 851, 868-869 (Alaska 2010). Moreover, the authority of the Office of Hearings and Appeals is limited to the scope identified in 7 AAC 49.170, that provides, in relevant part:

> Except as otherwise specified in applicable federal regulations … the role of the hearing authority is limited to the ascertainment of whether the laws, regulations, and policies have been properly applied in the case and whether the computation of the benefit amount, if in dispute, is in accordance with them.

The Office of Hearing and Appeals cannot deviate from its application of the facts to the statutes and regulations governing the administration of the Medicaid program, and has no authority to create exemptions from the requirements of the law for any reason(s).

Claimant did not meet her burden of proving the Division was incorrect in denying her Medicaid benefits in December 2010 and January 2011 because Claimant had non-excludable resources in excess of $2,000 during those months.

CONCLUSIONS OF LAW

1. On February 7, 2011, the Division correctly applied the Medicaid resource limit of $2,000 to determine that Claimant was not eligible to receive Medicaid benefits in December 2010 and January 2011.

2. Claimant did not meet her burden of proving by a preponderance of the evidence that she did not have resources valued in excess of $2,000 on December 1, 2010 and January 1, 2011, as required, to be eligible for Medicaid benefits during those months. 7 AAC 40.270(b).

DECISION

On February 7, 2011, the Division was correct to deny Claimant Medicaid benefits for December 2010 and January 2011 because Claimant owned a bank account resource valued at more than $2,000 on the first day of each of those months.

APPEAL RIGHTS

If for any reason Claimant is not satisfied with this decision, Claimant has the right to appeal by requesting a review by the Director. 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. To appeal, 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

DATED this June 9, 2011.

/signed/
Claire Steffens
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on June 9, 2011 true and correct copies of the foregoing were sent to:
Claimant, Certified Mail, Return Receipt Requested.

and to other listed persons (via e-mail), as follows:

[redacted], Hearing Representative
[redacted], Hearing Representative
[redacted], Chief, Policy & Program Dev.
[redacted], Administrative Assistant II
[redacted], Eligibility Technician I
[redacted], Staff Development & Training

/signed/
J. Albert Levitre, Jr., Law Office Assistant I