CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

609-588-2656

April 28, 2014

Donald D. Vanarelli, Esq.
242 St. Paul Street
Westfield. NJ 07090

Re: **FINAL AGENCY DECISION**
Alma Galletta
OAL Dkt. No. HMA 1057-12 & 5499-13N

Dear Counsel:

Enclosed is the Final Agency Decision rendered in the above-captioned matter.

If you are dissatisfied with the decision, you have the right to seek judicial review by the Appellate Division, Superior Court of New Jersey, Richard J. Hughes Complex, P.O. Box 006, Trenton, New Jersey 08625. A request for judicial review must be initiated within 45 days from the date of receipt of the decision.

Yours very truly,

Meredith Van Pelt, Esq.
Office of Legal and Regulatory
Liaison/DMAHS

MVP:go
Enclosure

C: Susan Silverstein, FHL
Louis M. Flora Esq.

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DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

A.G.,	:	
PETITIONER,	:	**ADMINISTRATIVE ACTION**
V.	:	**FINAL AGENCY DECISION**
DIVISION OF MEDICAL ASSISTANCE	:	**OAL DKT. NO. HMA 1057-12**
AND HEALTH SERVICES &	:	**& OAL DKT. NO. HMA 5499-13**
BERGEN COUNTY BOARD OF	:	
SOCIAL SERVICES,	:	
RESPONDENTS.	:	

As Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this matter, consisting of the Initial Decision, the documents in evidence and the contents of the OAL case file. No exceptions were filed in this matter. Procedurally, the time period for the Agency Head to render a Final Agency Decision is April 28, 2014 pursuant to an Order of Extension.

This matter concerns Petitioner's eligibility for the Global Options (GO) waiver program. Her May 2012 application, which was submitted through counsel, was denied due to excess income. Her income is comprised of Social Security and her private pension, totaling $1,446.72 per month. She also receives a pension from the Department of Veteran's Affairs (DVA) of $1,094 a month. At the time of application, Petitioner produced a letter dated May 23, 2012 from the DVA stating that $684 was Petitioner's pension and $410 was classified as Aid and Attendance (A&A). Pursuant to 20 C.F.R. § 416.1103 and DMAHS Medicaid Communication No. 87-22, Petitioner's A&A benefits were excluded from the financial eligibility determination. The DVA's clear characterization that $684 was a pension benefit led Bergen County to include it in the eligibility calculation and determined that Petitioner had countable income of $2,130.72. As this amount was above the GO limit of $2,094, benefits were denied by letter dated July 15, 2012.

During the hearing Petitioner, through new counsel, produced three more DVA letters dated February 14, 2013, February 19, 2013 and an undated letter. While February 19, 2013 again splits Petitioner's benefit attributing $417 to A&A, the February 14, 2013 characterizes the entire amount as A&A. Despite the inconsistent DVA letters, Bergen County relied on the February 14, 2013 letter to find Petitioner eligible and set an eligibility date of March 13, 2013. The Initial Decision determined that, despite there being no retroactive benefits permitted under GO, eligibility should be granted as of May 2012.[1] For the reasons that follow I hereby REVERSE the Initial Decision.

[1] It is because there are no retroactive benefits under GO that Bergen County "required the petitioner to re-apply for Medicaid." ID at 6. An individual may always reapply to Medicaid so as

The Initial Decision characterizes the determination that Petitioner meets financial eligibility as a change in position. (ID at 2). However, DMAHS has always excluded A&A from the eligibility determination. See Medicaid Communication No. 87-22.[2] It is the inconsistent declarations by the DVA regarding Petitioner's A&A that has caused her difficulties. The DVA, vested with the authority to establish rules and regulations regarding the administration and determination of these benefits, specifically provides direction regarding how to classify a pension when the beneficiary is applying for Medicaid. See http://www.benefits.va.gov/WARMS/M21_1MR3.asp.

Under the section entitled "When to Notify State Agencies for Benefits Payable for Purposes of Medicaid Eligibility" the DVA requires that:

> For purposes of Medicaid eligibility, advise the administering State agency of the amount of an award.
>
> Notes:
> • If the Aid and Attendance (A&A) allowance is payable, indicate what part of the monthly rate is considered to be for A&A.
> • In Improved Pension cases,
> □ report the amount for A&A as the difference between the gross amount of pension and the maximum amount of pension payable, excluding consideration of the housebound or A&A rates, or
> □ if pension would not be payable but for entitlement to the A&A allowance or Housebound rate, because income is in excess of the limit, report the entire amount of the payment as A&A. (Emphasis added).

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to obtain benefits during the pendency of the hearing. By doing so, Petitioner was able to establish eligibility as of March 2013 and begin to receive benefits.

[2] It should be noted that while the A&A benefit amount is excluded for eligibility purposes, the benefit is not excluded from resources or post-eligibility considerations and may affect eligibility. See POMS SI 00830.312 https://secure.ssa.gov/poms.nsf/lnx/0500830312 "Any unspent VA payments resulting from unreimbursed medical expenses are resources if retained into the calendar month following the month of receipt."

As the DVA's own instructions demonstrate when payment is to be classified as A&A and relying on what ought to be the DVA's accuracy and expertise in issuing the May 23, 2012 letter, Bergen County determined financial eligibility appropriately.

Furthermore, the prohibition of retroactive eligibility for GO cannot be dismissed. Home and Community based waiver programs, such as the GO waiver, are not entitlement programs since all persons who are eligible for Medicaid State Plan services are not entitled to waiver services. Though waivers must be approved by CMS, States retain great latitude in determining the composition and construction of a waiver. Indeed the States, at their option, may waive the requirements of 42 U.S.C.A. §1396a(a)(1), §1396a(a)(10)(B), or §1396a(a)(10)(C)(i)(III) of the Act, which concern respectively, statewide application of Medicaid, comparability of services, and income and resource rules applicable to individuals living in the community and set a cap on the number of waiver slots. The regulations clearly state that "[r]etroactive eligibility is not available to waiver program beneficiaries; no waiver service provided prior to the date of enrollment shall be considered for reimbursement." N.J.A.C. 10:49-22.1.[3]

As such, Petitioner needed to meet clinical eligibility for GO waiver programs is set by Federal rules.[4] Those rules require an evaluation of need as well as counseling regarding alternatives including the choice of receiving services in a nursing facility or community setting be done prior to entry into the

[3] Bergen County noted that Petitioner was advised that there were no retroactive benefits for GO when submitting her case for clinical review. See CP-2 form submitted in Certification of Louis Flora, Esq.

[4] Petitioner's income without any DVA benefit renders her ineligible for Medicaid benefits in the community. She can only have Medicaid pay for her care by meeting the clinical requirements for GO.

waiver. 42 C.F.R. § 441.302(c) and (d) and 42 C.F.R. § 441.303(d). Clinical eligibility for GO waiver services requires that an individual must be assessed by the State and meet nursing facility level of care. N.J.A.C. 8:85-2.1(a), the regulation addressing nursing home level of care, specifically states that: "Eligibility for nursing facility (NF) services will be determined by the professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." Clinical eligibility is established in real time through an assessment of medical conditions.

Additionally, prior to furnishing services under the waiver, there must be a "written plan of care based on an assessment of the individual's health and welfare need and developed by qualified individuals for each recipient under the waiver." 42 C.F.R. § 441.352(f). In this case, Petitioner's eligibility is governed by those rules and her eligibility for GO can only exist after these pre-requisites are met.

Moreover, the GO waiver permits the use of a higher income level - 300 percent of the SSI benefit amount which was $2,094 for 2012. In order for eligibility to be granted at this higher income level, the nursing level of care must be necessary.[5] Cf. 42 U.S.C.A. § 1396 and 1396a(30). In order to determine medically necessary services in a nursing home or pursuant to a home and community based waiver requiring nursing home level of care, a pre-admission screening is completed by "professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the

recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." N.J.A.C. 8:85-2.1(a). See also, N.J.S.A. 30:4D-17.10, et seq. This must be done prior to receipt of benefits so as not to create a program in the community using the higher income level.

As the aforementioned clinical factors and waiver requirements must be met prior to entry in the GO waive program, Petitioner is not entitled to benefits prior to that happening. Thus, I FIND her GO eligibility date must stand at March 13, 2013.

THEREFORE, it is on this 25th day of APRIL 2014

ORDERED:

That the Initial Decision in this matter is hereby REVERSED; and

That the March 13, 2013 eligibility date remains unchanged.

Valerie Harr, Director
Division of Medical Assistance
and Health Services

[5] Petitioner's income without any payment from the DVA renders her ineligible for Medicaid benefits in the community. She only eligible to have Medicaid pay for her care after it is determined that she meets the nursing home level of care. That was done as of March 13, 2013.