PMC and VSO Call Follow-Up

Below are the follow-up notes for the following topics discussing during the quarterly PMC and VSO conference call that took place on Wednesday, August 18th, 2021.

Topics

Competency Due Process and Usage of the Incompetency Notice Response

Issue: We received a question to clarify the use of the Incompetency Notice Response. The specific issue was that it was pointed out was that the use of this would not help or speed up the process to file them early in situations where you recognize that competency would be an issue (i.e. based on medical evidence such as Question #32 on VA Form 21-2680 that addresses whether the claimant has the ability to manage their benefit payments or direct someone to act on their behalf). In turn, VSOs don't use the Incompetency Notice Response and the family of the beneficiary wonders if they can do anything to expedite the process and they are sometimes advised by calling the National Call Center to complete an Incompetency Notice Response.

Follow-up Notes: A copy of the Incompetency Notice Response is included as an attachment to the email. The Incompetency Notice Response solicits for information regarding due process for incompetency on a VA Form 4138, Statement in Support of Claim. The goal of requesting this information is to streamline due process for incompetency proposals by either having the claimant tell us they agree with the proposal and appoint of a fiduciary or that they do not agree with the proposal and will send information to refute the proposal.

If there is evidence that the claimant cannot handle their own financial affairs or cannot direct someone to act on their behalf (Question #32 on VA Form 21-2680), we are required to send due process for a proposal of incompetency {38 CFR 3.353e/M21-1 III.iv.8.A.2.a.).

Note: An exception to sending due process would be for non-Veteran beneficiaries (e.g. surviving spouse) when there has been a judicial finding of incompetency, which is discussed further below. As such, if an Incompetency Notice Response or any kind of statement is sent along with the claim indicating the claimant cannot handle their financial affairs and would like a fiduciary appointed, due process is likely still going to be required. The information about a fiduciary submitted up front, or along with the claim, is helpful to know, but we are still required to send due process.

We can use the Incompetency Notice Response as evidence if they are submitted at any time when you as the VSO sends them in (like attendant affidavits) but claims processors will only enclose official VA forms in our notification letters. In Milwaukee, we send the Incompetency Notice Response information in our incompetency due process letters. This language is pasted onto a VA Form 4138 (Statement in Support of Claim). While sending in the Incompetency Notice Response before due process is issued is helpful information and will eventually be considered, it unfortunately won't speed up the due process

incompetency issue, since we are required to issue due process (unless there is a judicial finding of incompetency).

Here are the details on when we have a judicial finding of incompetency:

1) **For Veterans**, we still need a rating determination (and would need to develop for medical evidence if we don't have it) but the only rating decision needed would be the determination of competency (no proposal needed). M21-1 III.iv.8.A.1.b.; M21-1 III.iv.8.A.5.b.
2) **For non-Veterans** (surviving spouse, parent, or adult child), we do not need a rating decision at all (proposal or final). M21-1 III.v.9.B.2.h.

The following questions were asked during the call. We are providing answers to those questions.

Q: Once the incompetency issue has been assigned to the Fiduciary Hub is there a predetermined time frame that they are supposed to complete the appointment process by?
A: When due process is proposed and the EP 590 (which controls the due process issue) comes into the Fid Hub, they must wait 65 days before taking final action. Once final action is taken they must assign it to the appropriate Field Examiner (FE) within two days. The FE has a 37-day goal to complete the exam. Once the exam is submitted back into the Fiduciary Service Representative's (FSR) queue, the FSR has three days (or so) to complete the exam and officially appoint the fiduciary.

Q: Is there a way to have the families know that the Fid Team member coming to their home is a legal person? We have issues with other agencies that are trying to get Veteran to let them be the caretakers to get the AA money from the Veteran?
A: Currently no Field Examiners (FEs) are traveling to beneficiary's homes due to Covid-19. When our FEs do make home visits, they will call ahead 97% of the time to schedule the meeting. The FEs also drive government cars and have two forms of government IDs. The beneficiary/fiduciary can always call the hub to confirm an FE identity if needed.

The direct phone line to the Milwaukee Fid Hub: **1-888-407-0144 (select option #5)**.

Please also note the following reference to the Fiduciary Processing Manual that includes Fid Hub jurisdictions and contact information: I.1.A.2.a. Hub Jurisdictions and Contact Information

$90 Medicaid Rate Process

Issue: We received the following concern regarding the $90 Medicaid rate.

"I would love to discuss why VA can or will not amend their policy when it comes to the $90 Medicaid rate. I see this time and time again where on the application it is clearly marked that the claimant is in receipt of Medicaid but VA refuses to acknowledge it for whatever random reason i.e. facility is an assisted living facility vs. nursing home, etc. Bottom line if the claimant is in receipt of Medicaid and just wishes to receive the $90 payment it shouldn't matter where they are at. The vast majority of the time this cause more issues than the $90 is even worse which is unfortunate because for the vast majority of the claimants, that $90 is all the "spare" money they have on a month to month basis."

Follow-up Notes: We have attached a copy of the Attendant Affidavit on a VAF 4138 as requested during the call to this email.

We should clarify that expenses paid to an in-home care provider still need to be reported on a VA prescribed form such as a VA Form 8416 or 534EZ/527EZ before we can allow them as a deduction.

$90 Medicaid VA pension rate only applies to claimants who are in a Medicaid Approved nursing facility. It does not apply to claimants who are residents of an assisted living or independent living facility. The CFR and manual references listed below apply. Medicare's Nursing Home Compare website used to identify Medicaid-Approved Nursing facilities can be found here: https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true

38 CFR 3.551:

> (i) *Certain beneficiaries receiving Medicaid-covered nursing home care.* This paragraph (i) applies to a veteran without a spouse or child, to a surviving spouse without a child, and to a surviving child. Effective November 5, 1990, and terminating on the date provided in 38 U.S.C. 5503(d)(7), if such a beneficiary is receiving Medicaid-covered nursing home care, no pension or survivors pension in excess of $90 per month will be paid to or for the beneficiary for any period after the month in which the Medicaid payments begin. A beneficiary is not liable for any pension paid in excess of the $90 per month by reason of the Secretary's inability or failure to reduce payments, unless that inability or failure is the result of willful concealment, by the beneficiary, of information necessary to make that reduction.

V.iii.3.1.a. Provisions for Pension Reductions for Medicaid Covered Nursing Facility Care	**38 CFR 3.551(i)** limits to $90 per month the amount of pension that can be paid to a Veteran or surviving spouse with no dependents or to a surviving child who is • in a Medicaid-approved nursing facility, and • covered by a Medicaid plan for services furnished by the nursing facility. No part of the $90 monthly pension may be used to reduce the amount of Medicaid paid to a nursing facility.
V.iii.3.2.b. Definition: Medicaid-Approved Nursing Facility	A ***Medicaid-approved nursing facility*** is a nursing facility other than a State home that is approved to accept Medicaid patients

per Title XIX, section 1919, of the Social Security Act (42 U.S.C. 1396r).

References: For information on

- identifying Medicaid-approved nursing facilities, see **M21-1, Part V, Subpart iii, 3.3.a**, and
- the Medicaid policy for residential care settings for each State, see the U.S. Health and Human Services' website, **State Residential Care and Assisted Living Policy**.

V.iii.3.3.a. Identifying Medicaid-Approved Nursing Facilities

Use Medicare's **Nursing Home Compare** website (www.medicare.gov/care-compare/) to determine whether or not a nursing facility participates in a State Medicaid plan. If this website confirms that the facility participates in a State Medicaid plan, then the facility is considered to be a Medicaid-approved nursing facility.

Reference: For the definition of a Medicaid-approved nursing facility, see **M21-1 Part V, Subpart III, 3.2.b**.

The reference below lists some of the common allowable medical expenses. We highlighted the expenses we would consider as continuing medical expenses, or "projectable".

V.iii.1.G.2.c. List of Common Allowable Medical Expenses

The list below shows some of the common allowable medical expenses.

- adaptive equipment
- care by a health care provider (Payments to a health care provider for services performed within the scope of the provider's professional capacity are medical expenses. Cosmetic procedures that a health care provider performs to improve a congenital or accidental deformity or related to treatment for a diagnosed medical condition are medical expenses.)
- health insurance premiums
- institutional forms of care and in-home care
- medications, medical supplies, medical equipment, and medical food, vitamins, and supplements – certain requirements may apply
- smoking cessation products, and
- transportation expenses (payments for transportation for medical purposes).

Important: This list is ***not*** all-inclusive. Allow all expenses that are directly related to medical care.

This reference gives guidance on how we can allow medical expenses prospectively, or at the end of the reporting period (calendar year):

V.iii.1.G.4.f. Allowing Medical Expenses Prospectively

Normally, medical expenses are deducted from an award after the fact, based on the claimant's report of expenses actually paid.

However, under **38 CFR 3.272(g)**, medical expenses may be allowed prospectively if the claimant is paying recurring nursing home fees or other reasonably predictable medical expenses.

Notes:

- Do not select an arbitrary amount for a prospective medical expense deduction. Accept the amount claimed (less any identified expenses that do not meet medical expense criteria or do not appear to be reasonably predictable), or disallow the claim for prospective medical expenses, and calculate benefits on actual expenses reported at the end of the reporting period.
- Deduct an estimated actual amount of recurring medical expenses unless a claimant specifically requests zero prospective medical expenses.

Other Miscellaneous Questions/Issues Raised During the Call

Issue: "I continue to see development letters sent asking for documentation which is already in VBMS. Yesterday it was a death certificate which was scanned into VBMS the same day and was just four lines down from the development letter and very clearly marked as Death Cert. Just one example…"

Follow-Up Notes: Sometimes evidence can be mislabeled under incorrect "Document Types" when they are scanned into VBMS, or might be scanned in as part of another Document Type and thus, that specific type of evidence we are requesting might have been overlooked or missed by the claims processor. If you see instances of this (where evidence is being requested and is clearly in the VBMS file for us to review) please email the VSO inbox and let us know and we will review and expedite the claim if possible.

Question: Can they withdraw the A&A rate and request only the pension rate?

Follow-up Notes: Yes, but be aware that all evidence would need to be reviewed/considered to see if the claimant would potentially be over the Maximum Annual Pension Rate (MAPR), which may disqualify them from the underlying pension rate as well (e.g. if we were counting certain medical expenses which may no longer apply due to A&A status). Also, please note that due process is required before taking final action on severing entitlement to A&A. Please see the below references.

V.iii.2.A.1.f. Applicable Regulatory References for Certain A&A Status Issues

Use the table below to review the legal provisions for the A&A status issues listed.

A&A Status Issue	Regulatory Reference
Rating decisions for A&A status in Veterans pension cases.	• 38 CFR 3.351(c)(3), and • 38 CFR 3.352(a).
A&A status based on nursing home patient status.	38 CFR 3.351(c)(2).
Determining the effective date of A&A status.	• 38 CFR 3.401(a)(1) (Veterans) • 38 CFR 3.401(a)(3) (spouse of a Veteran) • 38 CFR 3.402(c) (surviving spouse), and • 38 CFR 3.404 (surviving parents).
Withdrawal of A&A status for any reason.	38 CFR 3.103(b)(2). ***Note***: The provisions of 38 CFR 3.103(b)(2) require sending a notice of proposed adverse action to a beneficiary. ***Reference***: For more information on withdrawal of A&A status, see M21-1, Part V, Subpart iii, 4.1.

V.iii.4.1. Handling Decisions to Reduce or Discontinue Pension, Including Awards Involving SMP

As always, please keep in mind the following email inbox for general questions and requests for priority claims: PMCVSO.VBAMIW@va.gov