April 14, 2025

[redacted]

RE: [redacted] v. WVDoHS
ACTION NO.: 25-BOR-1577

Dear [redacted]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Human Service. These same laws and regulations are used in all cases to assure that all persons are treated alike.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Eric L. Phillips
State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Leanne Soard, BFA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-1577**

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. This hearing was held in accordance with the provisions found in Chapter 700 of the Office of Inspector General Common Chapters Manual. This fair hearing was convened on April 2, 2025, on appeal filed March 10, 2025.

The matter before the Hearing Officer arises from the Respondent's untimely processing of the Appellant's application for Long-Term Care benefits.

At the hearing, the Respondent appeared by Leane Soard, Economic Service Worker Senior. Appearing as a witness for the Respondent was Drema Berry, Interim Program Manager for Long-Term Care. The Appellant appeared by [redacted] Medicaid Specialist-[redacted] Appearing as witnesses was [redacted], Office Manager-[redacted] and Assistant Office Manager-[redacted].

All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Electronic Mail correspondence dated December 20, 2024
D-2 Application for Long-Term Care Medicaid dated November 4, 2024
D-3 Verification Checklist dated January 27, 2025
D-4 Annual Statement of Activity for [redacted] dated April 17, 2024
D-5 Notice of Decision dated February 14, 2025
D-6 West Virginia Income Maintenance Manual 7.2.3

D-7 Electronic Mail correspondence dated March 11, 2025 and March 17, 2025
D-8 Application for Long-Term Care Medicaid dated March 17, 2025
D-9 [redacted] Contract dated February 21, 2025
D-10 Notice of Decision dated March 18, 2025
D-11 Notice of Contribution to the Cost of Care dated March 17, 2025

Appellant Exhibits:

A-1 West Virginia Income Maintenance Manual 1.6.6
A-2 [redacted] Center Transaction Report dated November 1, 2024-December 31, 2024

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) On August 12, 2024, the Appellant was admitted to [redacted] (Exhibit D-1)

2) On November 4, 2024, the [redacted], hereinafter Facility, applied for Long-Term Care Medicaid assistance on behalf of the Appellant. (Exhibit D-2)

3) On January 27, 2025, the Respondent issued a Verification Checklist (Exhibit D-3) requesting written verification of cash withdrawals from his bank accounts and the current cash value of his life insurance policy.

4) The Appellant provided verification of his cash withdrawals.

5) The Appellant provided an Annual Statement of Activity for [redacted] dated April 17, 2024. (Exhibit D-4)

6) The Respondent considered the information regarding the life insurance outdated and could not make an eligibility determination on the application.

7) On February 14, 2025, the Respondent issued a Notice of Decision (Exhibit D-6) to the Appellant informing him of the denial of his Long-Term Care application due to his failure to turn in all requested information.

8) The asset limit for Medicaid assistance is $2000.

9) In April 2024, the Appellant had a cash surrender value of his life insurance policy of $4126.78. (Exhibit D-4)

10) On March 16, 2025, the Appellant passed away. (Exhibit D-7)

11) On March 17, 2025, the Facility reapplied for Long-Term Care Medicaid assistance on behalf of the Appellant to obtain coverage for the months he resided at the facility. (Exhibit D-8)

12) The Facility provided verification that the Appellant's life insurance policy was placed in a preneed trust with the funeral effective February 21, 2025. (Exhibit D-9)

13) The Respondent determined that the Appellant was asset ineligible for LTC Medicaid assistance until February 21, 2025.

14) On March 18, 2025, the Respondent approved the Appellant's application for Long-Term Care Medicaid assistance effective March 1, 2025. (Exhibit D-10)

15) The Facility seeks reimbursement for the Appellant's care for November 2024 and December 2024.

APPLICABLE POLICY

West Virginia Income Maintenance Manual § 24.4.1.C.6 documents:

> The Worker must give the applicant at least 10 days for any requested information to be returned.
>
> The Worker must take eligibility system action to approve, deny, or withdraw the application within 30 days of the date of application.

West Virginia Income Maintenance Manual § 24.4.1.C.7 documents:

> If the DOHS failed to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 and DFA-6a, if applicable, to the client and note that the application is being held pending. When the information is received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.
>
> If the DOHS simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.
>
> For these cases, timely processing may mean acting faster than the maximum allowable time. If an application has not been acted on within a reasonable period of time and the delay is not due to factors beyond the control of the DOHS, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses

West Virginia Income Maintenance Manual § 10.6.6.A documents:

> A client is eligible to receive direct reimbursement for out-of-pocket medical expenses that would otherwise have been paid by Medicaid in these situations:
>
> • The client's coverage is interrupted due to agency delay or error unless the delay is due to factors beyond the control of the DOHS • An application is denied in error • A nursing home contribution is overpaid due to Worker error or failure to act promptly
>
> When determining if the client is eligible to receive direct reimbursement for out-of-pocket medical expenses, the Department of Human Services (DOHS) must act on each application or case action within a reasonable period of time unless the delay is due to factors beyond the control of the DOHS. A reasonable period of time must be interpreted on a case-by-case basis.
>
> Reimbursement for out-of-pocket medical expenses, including purchases of prescription drugs, is limited to those services covered by Medicaid. The client is reimbursed for the entire sum of his out-of-pocket expenses for those covered services, even if that expenditure exceeds the Medicaid fee schedule in effect at the time the expenditure was incurred.
>
> The Community Services Manager (CSM) is responsible for determining if the client is eligible to receive reimbursement for out-of-pocket medical expenses. If it is determined that the client is eligible to receive reimbursement, the CSM must submit a memorandum to the Bureau for Medical Services (BMS) Policy Unit requesting reimbursement, along with the original invoices for the medical expenses for which reimbursement is requested. The memorandum must contain the amount of the reimbursement that is due the client and the accompanying bills must be marked or highlighted to indicate if they are used for reimbursement.
>
> When the request for reimbursement is denied, the BMS Policy Unit notifies the CSM electronically of the decision. The local office notifies the client in writing of the denial.

DISCUSSION

Governing policy requires that the worker take action to approve, deny or withdraw the application within 30 days from the date of application. Additionally, policy provides that an individual may be eligible to receive direct reimbursement for out-of-pocket medical expenses which would have otherwise been paid by Medicaid when the coverage is interrupted due to agency delay, the application is denied in error, or a nursing home contribution is overpaid due to worker error or failure to act promptly.

The Appellant was admitted to the [redacted] (Facility) in August 2024. The Facility applied for LTC Medicaid assistance with the Respondent, on behalf of the Appellant, in November 2024. The Respondent failed to process the application or provide correspondence regarding requested additional information required to process the application until January 2025. In February 2025, the Respondent denied the Appellant's initial application, due to his failure to provide verification of the cash surrender value of a life insurance policy. In February 2025, the Appellant reassigned his life insurance policy to a preneed trust making him asset eligible for LTC Medicaid. The Facility provided a subsequent application in March 2025, in which the Respondent was able to make a complete eligibility determination and approved the Appellant's application for LTC Medicaid effective March 1, 2025.

The Facility brings forth this appeal on behalf of the Appellant. The Facility contends that the Appellant incurred out-of-pocket medical expenses while awaiting a decision on the initial application. The Facility seeks relief of payment of those incurred expenses from November and December 2024. The Facility opines that had the Respondent acted within the governing timeframes, the Appellant's application for services would have been facilitated timely.

Leanne Soard, Economic Service Worker Senior, testified that additional information concerning liquid assets and cash surrender values of a life insurance policy were requested in order to make an eligibility determination on the November 2024 application. The Facility provided an April 2024 Annual Statement regarding the life insurance policy (Exhibit D-4); however, Ms. Soard testified that the life insurance information was considered outdated and denied the Appellant's LTC application.

The Appellant assigned his life insurance policy in a preneed funeral contract on February 21, 2025. (Exhibit D-9) Ms. Soard testified that the Appellant remained ineligible for LTC Medicaid due to life insurance asset until the February 21, 2025 reassignment. The Appellant passed away on March 16, 2025 and the Facility reapplied for LTC Medicaid on March 17, 2025. The Respondent approved the new application, effective March 1, 2025, based on the new asset information.

[redacted] Appellant's representative, proclaimed the Facility was unaware of the Appellant's life insurance policy at initial application. [redacted] opines that if the Respondent provided correspondence on the additional information timely, the reassignment of the life insurance could have been completed sooner.

Based on the evidence, there is no question the Respondent failed to process the Appellant's application by the timeframes set forth by policy. However, by their own admission, the Appellant's representatives were unaware of the existing life insurance policy at the time of initial application. The Hearing Officer cannot speculate on whether expeditious correspondence from the Respondent would have facilitated the Appellant's ability to become asset eligible within the timeframe. Regardless of the timeliness of the application processing, the Appellant would have remained asset ineligible until the reassignment of the cash surrender value of his life insurance policy.

At initial application, the Appellant's assets exceeded the program limits; there the Appellant was

ineligible for LTC Medicaid and the Respondent was correct in its decision to deny the application. Because the Appellant was not eligible for benefits, there is no relief available for the out-of-pocket expenses incurred for November 2024 and December 2024.

CONCLUSIONS OF LAW

1) An application must be approved, denied, or withdrawn within 30 days from the date of application.

2) The Respondent denied the application on February 14, 2025.

3) The Respondent failed to render a timely decision of the Appellant's application.

4) At the time of application, the Appellant was asset ineligible for Medicaid assistance due to the cash surrender value of an existing life insurance policy.

5) The Appellant became asset eligible in February 2025, and his application for Medicaid assistance was approved March 1, 2025.

6) There is no relief available to the Appellant for out-of-pocket medical expenditures while he was ineligible for Medicaid assistance due to assets.

DECISION

It is the decision of the State Hearing Officer to uphold the February 14, 2025 decision to deny the Appellant's Medicaid assistance.

There is no relief to available to the Appellant for out-of-pocket medical expenses incurred in November 2024 and December 2024.

ENTERED this _____ day of April 2025.

_____

Eric L. Phillips
State Hearing Officer