May 15, 2025

REMOVED

RE: REMOVED v. WVDoHS
ACTION NO.: 25-BOR-1635

Dear Ms. REMOVED

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 Services. These same laws and regulations are used in all cases to ensure that all people 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,

Pamela L. Hinzman
State Hearing Officer
Member, State Board of Review

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

cc: Sean Hamilton, WVDoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

REMOVED

Appellant,

v. **Action Number: 25-BOR-1635**

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 REMOVED. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Office of Inspector General Common Chapters Manual. This fair hearing was convened on May 13, 2025.

The matter before the Hearing Officer arises from the February 10, 2025, decision by the Respondent to deny Long-Term Care Medicaid benefits and the Respondent's delay in processing the Appellant's Long-Term Care Medicaid application.

At the hearing, the Respondent appeared by Sean Hamilton, Economic Service Supervisor, WVDoHS. The Appellant was represented by REMOVED All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Electronic mail transmission from REMOVED to Long-Term Care Unit dated September 6, 2024, and Long-Term Care Medicaid application
- D-2 Case Comments from Respondent's computer system and Verification Checklist dated January 24, 2025
- D-3 Notice of Decision dated February 10, 2025

Appellant's Exhibits:

None

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) The Appellant submitted a Long-Term Care Medicaid application to the Respondent on September 6, 2024 (Exhibit D-1).

2) The Respondent began processing the Appellant's Long-Term Care Medicaid application on January 24, 2025 (Exhibit D-2).

3) On January 24, 2025, the Respondent sent the Appellant a Verification Checklist, requesting liquid asset verification to establish financial eligibility for Long-Term Care Medicaid benefits. The Respondent also requested that the Appellant provide an approved Pre-Admission Screening (PAS) form to establish medical eligibility for the program (Exhibit D-2).

4) The requested verification, including the approved PAS form, was not provided by the Appellant.

5) On February 10, 2025, the Respondent sent the Appellant a Notice of Decision, indicating that Long-Term Care Medicaid benefits were denied because all requested information was not provided (Exhibit D-3).

6) CommuniCare filed a fair hearing request on behalf of the Appellant on March 17, 2025, based on untimely processing of the Appellant's Long-Term Care Medicaid application.

APPLICABLE POLICY

West Virginia Income Maintenance Manual Chapter 24.8 states that applicants for nursing facility services must meet the asset test for their eligibility coverage groups, except for Modified Adjusted Gross Income (MAGI) groups.

West Virginia Income Maintenance Manual Chapter 24.12.2.A states:

> Before payment for nursing facility services can be made, medical necessity must be established for all clients. The PAS is the tool used for this purpose. The PAS is signed by a physician and then evaluated by a medical professional working with the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form, which is the only date used for establishment of medical necessity. The 60-day validity period applies, regardless of the reason for the completion.

West Virginia Income Maintenance Manual Chapter 7.2.3 states that the primary responsibility for providing verification rests with the client. It is an eligibility requirement that the client cooperate in obtaining necessary verification. The client is expected to provide information to which he has access and to sign authorizations needed to obtain other information. Failure of the client to provide necessary information or to sign authorizations for release of information results in denial of the application or closure of the active case, provided the client has access to such information and is physically and mentally able to provide it.

West Virginia Income Maintenance Manual Chapter 1.2.10.B states that if an applicant fails to provide verifications requested on the DFA-6 or verification checklist within the specified time limit and the application is denied, the Assistance Group must be given an opportunity to have its eligibility established for up to 60 days from the date of application without completion of a new form.

West Virginia Income Maintenance Manual Chapter 24.4.1.C.6 states:

> 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 Chapter 24.4.1.C.7 stipulates:

> 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 Chapter 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

Policy stipulates that a Long-Term Care Medicaid applicant must meet an asset test, and submit an approved PAS to establish medical eligibility, before payment for nursing facility services can be made. If an applicant fails to provide information requested on a Verification Checklist within the specified time limit, the application is denied. Policy requires that a worker take action to approve, deny or withdraw an application within 30 days from the date of application. 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, when the application is denied in error, or when a nursing home contribution is overpaid due to worker error or failure to act promptly.

Sean Hamilton, Economic Service Supervisor for the Respondent, acknowledged that the Department failed to process the Appellant's September 2024 Long-Term Care Medicaid application in a timely manner. However, once processing began, the Appellant's representative

failed to provide all requested verifications needed to establish both financial and medical eligibility for the REMOVED testified that all documentation required by the Respondent could not be obtained at the time the application was processed. REMOVED stated that the individual who was assisting in obtaining verifications for the Appellant was unavailable at the time the application was processed and had waited for the Respondent to process the application for five months.

There is no question that the Respondent failed to process the Appellant's application within the timeframes set forth in policy. However, the Appellant's representative ultimately failed to provide all verifications required by the Respondent to determine Long-Term Care Medicaid eligibility. Although speculative, it could be assumed that verification required to determine the Appellant's eligibility may not have been provided within specified timeframes had the Respondent requested it at an earlier date.

As verifications required to determine financial and medical eligibility were not submitted to the Respondent by the due date, the Respondent correctly denied the Appellant's September 6, 2024, Long-Term Care Medicaid application. While the Appellant's objection concerning the delay in application processing is noted, the Board of Review lacks authority to provide relief to the Appellant based on the processing delay. Since the Appellant was determined to be ineligible for Long-Term Care Medicaid benefits due to lack of asset/medical eligibility verification, there is no relief available for out-of-pocket medical expenses in conjunction with the September 2024 Long-Term Care Medicaid application.

CONCLUSIONS OF LAW

1) Policy requires an applicant to meet financial and medical eligibility criteria for Long-Term Care Medicaid before payment for nursing facility services can be made.

2) The primary responsibility for providing verification rests with the client/client's representative.

3) Failure of the client to provide necessary documentation results in denial of the application.

4) The Appellant failed to provide the necessary verification to establish Long-Term Care Medicaid eligibility in conjunction with her September 2024 Long-Term Care application.

5) Since the requested verification was not provided, the Respondent acted correctly in denying the Appellant's September 2024 Long-Term Care Medicaid application.

6) The Respondent failed to meet processing timelines for the Appellant's September 2024 Long-Term Care Medicaid application.

7) There is no relief available to the Appellant based on the Respondent's failure to meet timeliness guidelines.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's action to deny the Appellant's September 6, 2024, Long-Term Care Medicaid application. There is no relief available to the Appellant regarding the Respondent's failure to adhere to application processing time limits.

ENTERED this 15th day of May, 2025.

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Pamela L. Hinzman
State Hearing Officer