July 19, 2024

[redacted]

RE: [redacted] vs. WVDoHS
BOR Action No.: 24-BOR-2450

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 Services. These same laws and regulations are used in all cases to ensure 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: Tammy Conley, BFA
[redacted] Representative

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 24-BOR-2450**

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 July 17, 2024, on appeal filed June 11, 2024.

The matter before the Hearing Officer arises from the Respondent's failure to timely process the Appellant's application for Long-Term Care Medicaid assistance.

At the hearing, the Respondent appeared by Tammy Conley. The Appellant was represented by [redacted], Medicaid Eligibility Manager [redacted]. Appearing as a witness for the Appellant was [redacted] and [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

As a matter of record, this hearing was originally scheduled to convene on July 3, 2024; however, the Respondent's representative failed to appear and a continuance was granted in the matter. Neither party provided evidence for review.

Department's Exhibits:

None

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 is a resident of the [redacted], a long-term care facility.

2) On April 23, 2024, the Appellant applied for Long-Term Care Medicaid assistance with the Respondent.

3) The Respondent did not make an eligibility determination on the submitted Medicaid application prior to the requested hearing.

4) The Appellant receives [redacted] income.

5) By divorce decree, the Appellant's [redacted] income is diverted to his ex-spouse and unavailable to the Appellant.

6) On June 4, 2024, the Respondent requested additional information concerning the [redacted] income and bank records.

7) On June 11, 2024, the Appellant's representatives requested a fair hearing.

8) The Respondent has not acted on the requested additional information.

9) The Appellant submitted bank statements and the divorce decree with the initial application.

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.

Code of Federal Regulations Title 42 § 435.725 explains: The post-eligibility treatment of income for institutionalized individuals is as follows:

> ***Basic rules.***
> (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,
> (2) The individual's income must be determined in accordance with paragraph (e) of this section.
> (3) Medical expenses must be determined in accordance with paragraph (f) of this section.
> (b) ***Applicability.*** This section applies to the following individuals in medical institutions and intermediate care facilities.
> (1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under §435.110 or §435.120.
> (2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under §435.211.
> (3) Aged, blind, and disabled individuals who are eligible for Medicaid, under §435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.
> (c) ***Required deductions.*** In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) ***Personal needs allowance.*** A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—
(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;
(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and
(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.
(2) ***Maintenance needs of spouse.*** For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—
(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;
(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under §435.230; or
(iii) The amount of the medically needy income standard for one person established under §435.811, if the agency provides Medicaid under the medically needy coverage option.
(3) ***Maintenance needs of family.*** For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—
(i) Be based on a reasonable assessment of their financial need;
(ii) Be adjusted for the number of family members living in the home; and
(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under §435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.
(4) ***Expenses not subject to third party payment.*** Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—
(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.
(5) ***Continued SSI and SSP benefits.*** The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.
(d) ***Optional deduction: Allowance for home maintenance.*** For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—
(1) The amount is deducted for not more than a 6-month period; and
(2) A physician has certified that either of the individuals is likely to return to the home within that period.
(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and
(ii) A physician has certified that either of the individuals is likely to return to the home within that period.
(e) ***Determination of income*** —
(1) ***Option.*** In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.
(2) ***Basis for projection.*** The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.
(3) ***Adjustments.*** At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.
(f) ***Determination of medical expenses*** —
(1) ***Option.*** In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.
(2) ***Basis for projection.*** The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.
(3) ***Adjustments.*** At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

DISCUSSION

On April 23, 2024, the Appellant's representatives applied for Medicaid on behalf of the Appellant. To date, the Respondent has failed to act on the submitted application. The Appellant appeals the failure of the Respondent to approve, deny or withdraw the submitted application within thirty days.

The Respondent must demonstrate by a preponderance of the evidence that it correctly processed the Appellant's application timely.

Neither party provided evidence for review during the hearing process.

Tammy Conley, Economic Service Worker, admits that the Appellant's Medicaid application has not been processed in a timely manner in accordance with policy. Ms. Conley indicated that the Respondent requested additional information, concerning pension and bank accounts information, from the Appellant on June 4, 2024. Ms. Conley indicated that the requested information was due by June 14, 2024, but the Respondent failed to act on the application due to the Appellant's fair hearing request. Ms. Conley testified that there was concern regarding the Appellant's [redacted] income and his banking account information for the months of December 2023 through March 2024.

[redacted] Client's Representative, testified that a fair hearing was requested on the matter due to a lack of correspondence on an eligibility determination. [redacted] indicated that the Respondent verbally informed the Appellant's representatives of the requirement for additional information, but no documentation has been received to date. [redacted] indicated that a copy of the Appellant's divorce decree was submitted with the application which documents that the Appellant's [redacted] income is diverted to his ex-spouse and unavailable to the Appellant. Additionally, three bank statements from January 2024 through March 2024 were submitted with the initial application. Ms. Conley indicated that the information concerning the [redacted] income was submitted and conceded that the Respondent did have the requested bank accounts available to the Respondent for review at the application.

Governing policy concerning agency time limits dictates that the worker must take action to approve, deny, or withdraw the application within thirty days of the date of application. The worker must give the applicant at least 10 days for any requested information to be returned, should the agency require necessary verifications. If the agency simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the agency acted in a timely manner.

To date, the Respondent has failed to make an eligibility determination on the Appellant's Medicaid application. The Respondent admitted that the application has been delayed and not completed within thirty days. While the Respondent requested additional information, forty-three days after the submitted application, such request was invalid and unnecessary due the agency delay because the information had been submitted at the initial application and known to the Respondent. Because the information has been provided, the Respondent has failed to adhere to its own policy and make an eligibility determination within thirty days of the date of application. Policy outlines if the agency simply failed to act promptly on information already received, benefits are retroactive to the date eligibility would have been established had the agency acted in a timely manner. Because the agency has failed process the application timely, all information should be examined promptly and benefits be administered to the date eligibility would have been established had the agency acted in a reasonable manner.

CONCLUSIONS OF LAW

1) An eligibility determination for Long-Term Care Medicaid assistance must be made within thirty days of the date of application.

2) All information has been provided to the Respondent and a prompt eligibility determination in the matter is necessary.

3) The Respondent failed to make an eligibility determination within its time limits in accordance to policy.

DECISION

It is the decision of the State Hearing Officer that the Respondent failed to process the Appellant's Medicaid application timely according to policy guidelines. Therefore, this case is **REMANDED** to the Respondent to process the application and notify the Appellant of its decision immediately.

ENTERED this _____ day of July 2024.

_____

Eric L. Phillips
State Hearing Officer