October 17, 2024

[redacted]

RE: [redacted] v. WVDoHS
ACTION NO.: 24-BOR-3281

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 West Virginia Department of Human Services. 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: Susan Snider, BFA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 24-BOR-3281**

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 October 16, 2024, on appeal September 25, 2024.

The matter before the Hearing Officer arises from the September 11, 2024 decision by the Respondent to deny the Appellant's application for Long-Term Care financial assistance.

At the hearing, the Respondent appeared by Susan Snider, Economic Service Worker. The Appellant appeared by [redacted] Appellant's son, Attorney-In-Fact and Estate Executor. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Application for Long-Term Care Medicaid dated November 15, 2023
D-2 Notice of Decision dated September 11, 2024
D-3 Bank Statements
D-4 Asset Determination Summary
D-5 Case Comments
D-6 West Virginia Income Maintenance Manual § 5.4, 7.2.3, 7.2.4

Appellant's Exhibits:

A-1 Vital Registration Office-Certificate of Death
A-2 Resident Admission Agreement

A-3 [redacted] Receipt dated July 31, 2024
A-4 Timeline of Events

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 November 15, 2023, the Appellant completed an application for Long-Term Care Medicaid assistance. (Exhibit D-1)

2) The Respondent received and acknowledged receipt of the application on November 15, 2023. (Exhibit D-1)

3) On November 20, 2023, the Appellant was admitted to [redacted] Long-Term Care Facility.

4) The Appellant deceased on March 20, 2024.

5) The Respondent processed the application on July 22, 2024 and requested additional information concerning the Appellant's checking account information. (Exhibit D-5)

6) The Appellant's Attorney-In-Fact presented bank statement information from August 2023, September 2023, October 2023, November 2023, December 2023, January 2024 and May 2024. (Exhibit D-3)

7) The Respondent determined the Appellant's countable assets to be $10505.32. (Exhibit D-4)

8) The asset limit for Long-Term Care Medicaid eligibility is $2000.00.

9) On September 11, 2024, the Respondent issued a Notice of Decision (Exhibit D-2) informing the Appellant's Attorney-In-Fact, that his mother's application for Long-Term Care Medicaid assistance had been denied effective April 1, 2024, due to excessive assets and that the Appellant was deceased.

APPLICABLE POLICY

West Virginia Income Maintenance Manual § 5.4 documents in part:

> The asset limits for Medicaid is $2,000.

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 § 24.4.1.C.10 documents:

> Medicaid Eligibility Medicaid eligibility begins on the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.
>
> Payment for Nursing Facility Services Payment for nursing facility services begins on the earliest date the three conditions described below are met simultaneously. Payment for nursing facility services may be backdated up to three months prior to the month of application when all the conditions described below are met for that period.
> • The client is eligible for Medicaid; and
> • The client resides in a Medicaid-certified nursing facility; and

• There is a valid pre-admission screening (PAS) or, for backdating purposes only, physician's progress notes or orders in the client's medical records. Section 24.12 contains information about the PAS and details specific situations in which the progress notes or orders are used.

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 September 11, 2024, the Respondent denied the Appellant's application for Long-Term Care Medicaid assistance effective April 1, 2024, due to excessive assets. The Appellant deceased prior to the Respondent's eligibility determination. The Appellant, through her Attorney-In-Fact and Estate Executor, appealed the Respondent's decision citing that the Respondent's failure to act upon the application timely prohibited the Appellant's ability to establish eligibility prior to her death.

On November 15, 2023, [redacted], the Appellant's Attorney-In-Fact, completed a Long-Term Care Medicaid application for his mother and submitted it to the local [redacted] Department of Health and Human Resources. The processing of the Appellant's application was delayed until July 2024, when it was received by the newly created statewide Long-Term Care (LTC) unit. The statewide LTC unit backdated the application three months to April 2024 and requested additional information which included verification of the Appellant's liquid assets. Upon receipt of the liquid asset information, the Respondent denied the application due to excessive assets, effective April 2024.

[redacted], the Appellant's Attorney-In-Fact, contends that the Respondent's failure to timely communicate information regarding his mother's application prevented her from spending down her assets prior to her death which affected her eligibility for Long-Term Care assistance. [redacted] purported that his mother maintained a checking account and only spent money for living expenses. After the Appellant's death, [redacted] paid the Long-Term Care Facility at [redacted] the remaining balance of his mother's checking account of $16,284.06. (Exhibit A-3)

Governing policy requires that the worker must take action to approve, deny, or withdraw the application within 30 days of the date of the application. Additionally, policy allows Medicaid applications to be backdated three months when all eligibility requirements are met. Evidence reveals that the Appellant's application was submitted locally on November 15, 2023. While the processing worker noted in evidence (Exhibit D-5) that the application was not scanned into the eligibility system until July 15, 2024, the application is clearly affixed with a receipt date stamp of November 15, 2023, from the local office and a scanned date of November 15, 2023. Evidence is clear that the application was submitted in November 2023, and the Respondent failed to make an eligibility determination date from November 2023, or the three months prior allowed by policy. Because the Respondent failed to process the Appellant's application in a reasonable manner, it failed to adhere to its own policy and make an eligibility determination within thirty days of the date of application. Therefore, the Respondent's decision to deny the Appellant's application,

effective April 2024, cannot be affirmed.

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) Medicaid eligibility may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

3) The Appellant submitted her application for eligibility determination on November 15, 2023.

4) The Respondent made an eligibility determination in July 2024, backdating the application for consideration to April 2024.

5) The Respondent failed to process the Appellant's application within thirty days of November 15, 2023 and consider three months prior to the application date as allowed by governing policy.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's September 11, 2024 decision to deny the Appellant's application due to excessive assets. This case is **REMANDED** to the Respondent to process the application from the date of the application and consider the three months prior to the application date as allowed by policy.

ENTERED this _____ day of October 2024.

_____

Eric L. Phillips
State Hearing Officer