STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

Bill J. Crouch
Cabinet Secretary

BOARD OF REVIEW
Raleigh County DHHR
407 Neville Street
Beckley, WV 25801

Jolynn Marra
Inspector General

March 9, 2022

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 22-BOR-1172

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 Health and Human Resources. 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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: Sara Shawver
Melissa Midkiff, [redacted] DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 22-BOR-1172**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

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 West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on March 9, 2022, on appeals filed September 29, 2021, November 18, 2021 and February 16, 2022.

The matter before the Hearing Officer arises from the June 17, 2021, decision by the Respondent to deny Medicare Premium Assistance Program benefits.

At the hearing, the Respondent appeared by Melissa Midkiff, Economic Service Worker. The Appellant appeared by [redacted], Appeals and Hearing Specialist with [redacted]. Both witnesses were sworn, and the following documents were admitted into evidence.

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) An application for Medicare Premium Assistance Program benefits was submitted on behalf of the Appellant on May 25, 2021.

2) The Appellant listed [redacted] as her authorized representative on Appendix C of the application.

3) The Respondent requested verification of the value of Appellant's bank account, life insurance policy, burial plot and pension income on or around June 8, 2021. The verification checklist was mailed to the Appellant.

4) The Respondent denied the Appellant's application on June 23, 2021, when verification of the Appellant's life insurance policy had not been received. The notice of denial was mailed to the Appellant.

5) On July 16, 2021, [redacted], contacted the Respondent about the Appellant's application and was advised of the denial.

6) On September 29, 2021, verification of the Appellant's income and assets were faxed to the Respondent.

7) [redacted] included a request for hearing over the denial of Medicare Premium Assistance benefits on behalf of the Appellant with the faxed verifications.

8) The Appellant reapplied for Medicare Premium Assistance Program benefits on October 6, 2021.

9) Specified Low Income Medicare Beneficiary (SLIMB) benefits were approved for the Appellant effective October 1, 2021.

10) [redacted] additionally requested appeals on the denial of Medicare Premium Assistance Program benefits on November 18, 2021 and February 16, 2022.

11) The Appellant contested the denial of Medicare Premium Assistance Program benefits for May, June, July, August and September 2021.

APPLICABLE POLICY

West Virginia Income Maintenance Manual §1.4.5.B states an adult non-assistance group (AG) member may participate in the interview as an authorized representative (AR) of the AG, either with or without an AG member. This individual must be authorized and designated in writing by an adult member of the AG or by any AG member if there is no member at least age 18. The authorized representative must have sufficient knowledge of the AG's circumstances to provide the necessary information. The authorized representative may act on the AG's behalf in making

an application, completing a redetermination or reporting information during the certification period. Different individuals may be selected for each activity which may involve an authorized representative, i.e., one AR may participate in an interview and a different AR may report a change. Unless it is otherwise documented from the AG, the authorized representative who completes the application is assumed to be authorized to report changes as well. A recording must be made in case comments regarding the authorized representatives' status. The AG must be informed that it is responsible for repayment of any over issuance caused by erroneous information provided by the authorized representative.

West Virginia Income Maintenance Manual §1.6.5 states the applicant may designate an authorized representative to act on his behalf. Such a designation must be in writing and include the applicant's signature. Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation. The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization to the DHHR. The authorized representative is responsible to the same extent as the client being represented, including confidentially of any information regarding the client provided by the agency and agreeing to the terms of the Rights and Responsibilities. Examples of documents the applicant may submit with the Medicaid application to verify he has designated an authorized representative include the Single Streamlined Application (DFA-SLA-1, Appendix C).

Code of Federal Regulations Title 42 §435.923 states (a)(1) the agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. Such a designation must be in accordance with paragraph (f) of this section, including the applicant's signature, and must be permitted at the time of application and at other times.

(2) Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

(b) Applicants and beneficiaries may authorize their representatives to –

(1) Sign an application on the applicant's behalf;
(2) Complete and submit a renewal form;
(3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;
(4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

(c) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon

which the individual or organization's authority was based. Such notice must be in accordance with paragraph (f) of this section and should include the applicant or authorized representative's signature as appropriate.

(d) The authorized representative –

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents;
(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(e) The agency must require that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must affirm that he or she will adhere to the regulations in part 431, subpart F of this chapter and at 45 CFR 155.260(f) (relating to confidentiality of information), §447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

(f) For purposes of this section, the agency must accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives must be accepted through all of the modalities described in §435.907(a).

West Virginia Income Maintenance Manual §1.4.10 states if, because of an agency error, an application has not been acted on within the required time limit, corrective action must be taken immediately.

Department of Health and Human Resources' Common Chapters Manual §710.13.B states reasons for hearing include:

Denial – Any time an applicant or recipient alleges that he or she was excluded incorrectly or wrongfully from public assistance in a program administered by the Department or the Federally Funded Marketplace (FFM). Examples of denial may include, but are not limited to:

- Denial of the right to apply;
- Denial of cash assistance, Medicaid or SNAP;
- Denial of adequate assistance or SNAP;
- Denial of support services through WV WORKS;
- Denial of Medicaid coverage for procedures, services or durable medical equipment;
- Denial of benefits due to race, color, national origin, age, sex, disability, or religion;
- Denial of expedited services for SNAP; or
- Denial of a request for an extension of the 60-month lifetime limit for WV WORKS.

Department of Health and Human Resources' Common Chapters Manual §710.17.A states once a fair hearing request is received by the office or bureau that issued the adverse action, that office or bureau shall, within two business days, send a referral packet to the Board of Review central office.

Code of Federal Regulations 42 CFR §431.220 states the State agency must grant an opportunity for a hearing to any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness including an initial or subsequent decision regarding eligibility.

DISCUSSION

Pursuant to federal regulation and agency policy, an applicant may designate an individual or entity as an authorized representative to act on his or her behalf. Such a designation must be in writing and include the applicant's signature. The applicant may authorize the representative to sign an application on his or her behalf, complete and submit a renewal form, and receive copies of the notices and other communications from the agency.

The Respondent denied the Appellant's application for Medicare Premium Assistance benefits for failure to verify the value of her life insurance policy. The Appellant designated [redacted] as her authorized representative on the application for Medicare Premium Assistance program benefits. The Respondent failed to act upon this information and sent all correspondence regarding the action taken on the Appellant's application to the Appellant only.

As the Appellant's authorized representative, [redacted] should have received notice that the Appellant's application was pending for verification of her assets to act on her behalf to provide that information. Additionally, the Respondent was required to notify [redacted] in writing of the denial of the Appellant's application. Whereas the Respondent failed to follow policy in providing written notice of the status of the Appellant's application, the Respondent must take corrective action to evaluate the Appellant's eligibility for Medicare Premium Assistance program benefits retroactive to the date of initial application in May 2021.

Furthermore, the Appellant was denied the right to appeal the denial in hearing requests made on her behalf by [redacted] in September 2021 and November 2021. Federal regulations and agency policy require that any individual must be given the opportunity for a fair hearing who requests it because if individual believes action taken on his or her case was taken erroneously.

CONCLUSIONS OF LAW

1) An applicant may designate an individual or entity as an authorized representative to act on his or her behalf if the designation is made in writing and includes the applicant's signature.

2) The Appellant designated [redacted] as her authorized representative on the May 25, 2021, application for Medicare Premium Assistance program benefits.

3) The Respondent failed to notify [redacted] of the information needed to determine the Appellant's eligibility for Medicare Premium Assistance benefits and the subsequent denial of the application.

4) The Appellant was deprived of her right to have [redacted] act on her behalf in providing the information needed to determine eligibility.

5) The Respondent must reevaluate the Appellant's eligibility for Medicare Premium Assistance program benefits retroactive to the initial application in May 2021.

DECISION

It is the decision of the State Hearing Officer to **reverse** the decision of the Respondent to deny the Appellant's application for Medicare Premium Assistance program benefits for May, June, July, August and September 2021. The matter is hereby **remanded** to the Respondent to evaluate the Appellant's eligibility retroactively to the date of the May 25, 2021, application.

ENTERED this 9th day of March 2022.

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Kristi Logan
Certified State Hearing Officer