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

Bill J. Crouch
Cabinet Secretary

BOARD OF REVIEW
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Jolynn Marra
Interim Inspector General

December 27, 2021

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 21-BOR-2367

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,

Angela D. Signore
State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29
cc: Sara Pemberton, WV DHHR, [redacted]

BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 21-BOR-2367**

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' (DHHR) Common Chapters Manual. This fair hearing was convened on December 21, 2021.

The matter before the Hearing Officer arises from the September 14, 2021, decision by the Respondent to deny the Appellant's application for Long-Term Care (LTC) Medicaid benefits.

At the hearing, the Respondent appeared by Sara Pemberton, Economic Service Worker. The Appellant appeared *pro se* and was represented by [redacted], Business Office Manager, [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 West Virginia Department of Health and Human Resources (WV DHHR) Verification Checklist, dated September 01, 2021
D-2 WV DHHR Income Maintenance Manual (IMM) §§ 24.8, 24.8.1, and 24.8.1.A
D-3 Electronic mail (E-mail) submission of LTC Medicaid Application for [redacted], dated August 27, 2021
D-4 WV IMM § 5.4
D-5 WV IMM §§ 5.5 through 5.5.48.B
D-6 WV IMM § 7.2.3

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) On August 27, 2021, a Long Term Care (LTC) Medicaid application was submitted on behalf of the Appellant. (Exhibit D-2)

2) On September 01, 2021, the Department issued a verification checklist and requested that the listed verifications be provided to the Department by September 13, 2021, in order to establish the Appellant's eligibility for Medicaid Long-Term Nursing coverage. (Exhibit D-1)

3) The Appellant failed to provide the requested documentation listed on the September 01, 2021, verification checklist by the September 13, 2021 due date.

3) On September 14, 2021, the Department issued a notice advising the Appellant that her application for LTC Medicaid benefits was denied due to failure to return the requested verification by September 13, 2021.

4) The September 14, 2021 notice further advised that submission of the following verifications were not received: "Proof of unearned income gross payment amount, proof of marital status, proof of life insurance policy cash surrender value, and proof of life insurance policy type."

5) On November 12, 2021, the Appellant's Representative requested a Fair Hearing based on the September 14, 2021 Notice of denial of LTC Medicaid eligibility.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 5.3.4 Accessibility of Assets provides, in part:

> A client may not have access to certain assets. In order to be considered an asset, the asset must be owned by, or available to, the client. If the client cannot legally dispose of the asset, it is not treated as an asset.
>
> Examples of inaccessibility include, but are not limited to, the following:
>
> - Legal proceedings such as, probate, liens (other than those required for financing the asset). Items encumbered, or otherwise unavailable, due to litigation are not considered assets until the court proceedings are completed and a court decision is reached. The DHHR is required to follow the dictates of the court order.

WV IMM § 7.2.3 Client Responsibilities provides, in part:

The primary responsibility for providing verification rests with the client. It is an eligibility requirement that the client cooperate in obtaining necessary verifications. 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.

WV IMM § 9.2.1 DFA-6, Notice of Information Needed provides, in part:

The DFA-6 may be used during any phase of the eligibility determination process. At the time of application, it is given or mailed to the applicant to notify him of information or verification he must supply to establish eligibility. When the DFA-6 is mailed at the time of application, the client must receive the DFA-6 within five working days of the date of application.

If the client fails to adhere to the requirements detailed on the DFA-6, the application is denied or the deduction disallowed, as appropriate. The client must be notified of the subsequent denial by form DFA-NL-A.

WV IMM § 24.1 Introduction provides, in part:

All LTC programs require a determination of medical eligibility, as well as a determination of financial eligibility conducted by the Worker.

WV IMM § 24.1 Application/Redetermination provides, in part:

Payment for nursing facility care is a service available to eligible Medicaid clients. Eligibility for payment for nursing facility services is determined in any of the following four ways, in priority order; also see Section 24.7.2.

1. Qualified Medicare Beneficiary (QMB) clients, when Medicare is participating in the nursing facility payment, or will participate when the client enters the nursing facility.

2. Full coverage Medicaid clients.

3. Nursing Facility coverage group – nursing facility residents who meet a special income test.

4. Supplemental Security Income (SSI)-Related/Monthly Spenddown – when the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established.

WV IMM § 24.8 Assets provides, in part:

Applicants for nursing facility services must meet the asset test for their eligibility coverage groups, except for Modified Adjusted Gross Income (MAGI) groups. The asset level for those eligible in the Nursing Facility coverage group and Supplemental Security Income (SSI)- Related/Monthly Spenddown is the same as SSI-Related Medicaid When both spouses are institutionalized and both apply for nursing facility services, the SSI-Related Medicaid asset limit for a couple is used to determine eligibility.

WV IMM § 24.8.1 Assets provides, in part:

When an institutionalized person has a spouse in the community, once the Worker determines the value of the assets as governed by Chapter 5, he completes an Asset Assessment, described below. The purpose of the Asset Assessment is to allow the spouse of an institutionalized individual to retain a reasonable portion of the couple's assets and to prevent the impoverishment of the community spouse.

WV IMM § 24.8.1.A Assets provides, in part:

When determining eligibility for nursing facility services for an individual who has a community spouse, the Worker must complete a one-time assessment of the couple's combined countable assets, called an Asset Assessment.

A legally married individual and his spouse, although separated, are treated as a couple for the Asset Assessment, regardless of the length of the separation.

DISCUSSION

Pursuant to policy, all LTC programs require a determination of medical eligibility, as well as a determination of financial eligibility. All full coverage Medicaid clients who need Medicaid payment for nursing facility services must complete and return the Application for Long Term Care Services. When eligibility cannot be determined without additional information, the Department is required to send written notice requesting the needed information. The Department worker must inform the client that the application is being held pending for no less than 10 days. Additionally, when an institutionalized person has a spouse in the community, the Department must complete an Asset Assessment to allow the spouse of the institutionalized individual to retain a reasonable portion of the couple's assets to prevent the impoverishment of the community spouse. A legally married individual and his/her spouse, although separated, are treated as a couple for the Asset Assessment, regardless of the length of the separation. Failure of an individual to provide necessary information results in denial of the application, provided the individual has access to such information and is physically and mentally able to provide it.

On August 27, 2021, a LTC Medicaid application was submitted on behalf of the Appellant. In order to further evaluate the Appellant's eligibility, a verification checklist was issued on September 01, 2021, requesting additional documentation be provided to the Department by September 13, 2021, in order to establish the Appellant's eligibility for Medicaid LTC coverage. When the Appellant failed to provide requested documentation listed on the September 01, 2021 verification checklist by the September 13, 2021 due date, the Department issued an additional notice advising the Appellant that her application for LTC Medicaid benefits was denied due to

failure to return the requested verifications.

The Appellant argued that she has been estranged from her spouse since 2012. She testified that attempts to obtain the spouse's income verification were made, but because her estranged spouse was uncooperative, the efforts were unsuccessful. The Department argued that the Appellant's application was denied based on several factors, and not solely on the lack of cooperation from the Appellant's estranged husband. The Department further testified that in addition to the Appellant's inability to provide spousal income verification, the Appellant also failed to provide proof of Workers' Compensation wages, photocopies of the Appellant's identification (ID), a photocopy of the Appellant's birth certificate, social security card, and Medicare card, the policy number, face value, and cash surrender value of the Appellant's life insurance policy, as well as a valid Pre-Admission Screening (PAS) signed by a physician. By the Appellant Representative's own admission, the listed verifications were readily accessible and could have been submitted. However, when it was determined the Appellant's estranged spouse would be uncooperative in assisting the Appellant with his income verification, the additional documentation was purposely withheld since the Appellant's application "would automatically be denied."

Pursuant to policy, failure of an applicant to provide necessary information results in the denial of the application unless an individual does not have access to information or is physically and mentally unable to provide it. While the Appellant may not have had access to her estranged spouses income, policy still requires the submission of the supplementary requested verifications that are accessible. Because the Appellant failed to provide the Respondent with requested documentation required by policy, the Respondent was unable to complete an Asset Assessment as a result of her noncooperation. Therefore, the Respondent's denial of the Appellant's LTC Medicaid based on failure to return requested information for eligibility purposes is affirmed.

CONCLUSION OF LAW

Pursuant to policy, because the Appellant failed to provide the requested verification by the established due date of September 13, 2021, the Department was correct to deny the Appellant's application for LTC Medicaid benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's August 27, 2021, application for Long Term Care (LTC) Medicaid benefits.

ENTERED this *27th* day of December 2021.

Angela D. Signore
State Hearing Officer