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

Bill J. Crouch
Cabinet Secretary

Board of Review
416 Adams Street Suite 307
Fairmont, WV 26554
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Jolynn Marra
Interim Inspector General

June 11, 2019

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 19-BOR-1438

Dear Ms. [redacted]

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the Board of Review 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 that may be taken if you disagree with the decision reached in this matter.

Sincerely,

Tara B. Thompson
State Hearing Officer
State Board of Review

Enclosure: Appellant's Recourse
Form IG-BR-29

cc: Jill Metz, [redacted] County DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **ACTION NO.: 19-BOR-1438**

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 May 15, 2019, on an appeal filed March 19, 2019.

The matter before the Hearing Officer arises from the June 6, 2018 determination by the Respondent to deny the Appellant's application for Medicare Premium Assistance.

At the hearing, the Respondent appeared by Jill Metz, [redacted] County DHHR. The Appellant was represented by [redacted], [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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) On May 21, 2018, the Appellant submitted an application for Medicare Premium Assistance and indicated on her application that [redacted] was her authorized representative.

2) On June 6, 2018, the Respondent issued a notice to the Appellant advising that her application for Medicare Premium Assistance was being denied pursuant to West Virginia Income Maintenance Manual §7.2.3, due to the Appellant's failure to submit proof of the value of her individual retirement asset.

3) At the time of application, the Respondent worker did not add [redacted] as an authorized representative for the Appellant.

4) The Respondent did not issue a written notice to the Appellant's authorized representative requesting document verification of the Appellant's retirement asset.

5) The Respondent did not issue a copy of the June 6, 2018 denial notice to the Appellant's authorized representative.

6) In 2019, the Appellant's authorized representative submitted the Appellant's March through May 2018 bank and IRA statements.

7) The Respondent approved the Appellant's Medicaid Specified Low-Income Medicare Beneficiary (SLIMB) Medicare premium assistance benefits and back-dated the Appellant's SLIMB coverage to December 2018.

8) The Respondent's computer system would not permit back-dated SLIMB coverage preceding December 2018.

APPLICABLE POLICY

Authorized Representative:

West Virginia Income Maintenance Manual (WVIMM) Glossary provides:

> *Authorized Representative*: an individual designated by an applicant or client ot act on his or her behalf.

WVIMM §1.2.1.A Right to Apply provides in part:

> The Applicant may designate a representative to act on their behalf, known as an "Authorized Representative."

Verification Requests:

WVIMM §1.2.3.A General provides in part:

> The worker has the following general responsibilities in the application process. The worker must [emphasis added]:
> - Obtain all pertinent, necessary information through verification, when appropriate
> - Ensure that proper case recordings are made to document the worker's actions and the reasons for such actions.

WVIMM §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 she 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, provided the client has access to such information and is physically and mentally able to provide it.

WVIMM §7.2.4 Worker Responsibilities provides in part:

> The worker has the following responsibilities in the verification process:
> - At application, the worker must list all required verification known at the time
> - If the client is unsuccessful in obtaining information, or if physical or mental limitations prevent his compliance, and there is no one to assist him, the worker must document attempts to obtain the verification.

WVIMM §1.6.4 Due Date of Additional Information provides in part:

> The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.

WVIMM §9.3.5 Notice of Information Needed provides in part:

> If it becomes clear that additional information or verification is needed, the DFA-6 is used to notify the client in writing of the needed information and the date by which the information must be received.

WVIMM §9.3.5.A Case Maintenance for All Programs provides in part:

> The date entered in the DFA-6 must be at least 10 days from the date of the DFA-6 is completed. If the client fails, without good cause, to provide the information by the established date, a DFA-NL-C must be sent to notify the client of the failure and the resulting case action.

Establishing Back-Dated Coverage:

WVIMM §1.6.6 Agency Delays provides in part:

> When the Department fails to request necessary verification, the worker must immediately send the eligibility system verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received, and the client is determined eligible, medical coverage is retroactive to the date eligibility would have been established.[emphasis added]

WVIMM §23.12.2.B Period of Eligibility provides in part:

> The beginning date of SLIMB eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

WVIMM §23.12.2.C provides in part:

> The information in Section 23.12.1.C also applies to SLIMB cases.

WVIMM §23.12.1.C provides in part:

> Once the client is included in the state buy-in process and thus begins the state's payment of the client's Medicare premium to the Social Security Administration (SSA), SSA refunds all the Medicare premiums withheld during the time that the state should have paid the premium. Such reimbursement to the client does not affect the client's eligibility.

DISCUSSION

The Appellant applied for Medicare Premium Assistance and was denied due to failure to submit all requested information. The Appellant's representative contended that she was not notified of the Respondent's request for documentation nor the Appellant's application denial. As verification has now been submitted and the Appellant has been approved for Medicaid SLIMB benefits, the Appellant's representative requests that the Appellant's Medicare Premium Assistance benefits be backdated to May 2018, when the Appellant applied. The Respondent bears the burden of proof and must demonstrate by a preponderance of evidence that the Appellant's Medicare Premium Assistance benefit application was properly denied due to the Appellant's failure to provide requested information and that the Appellant's approved Medicaid SLIMB benefits should not be back-dated beyond December 2018.

Authorized Representative:
Pursuant to policy, the Appellant was entitled to appoint a representative to act on her behalf during the application process. The Respondent testified that even though the Appellant had appointed a

representative that the Respondent worker failed to reflect the representative in the case. Policy provides that the Respondent worker had a responsibility to accurately reflect the Appellant's information through proper case recordings. The Respondent worker's failure to reflect the Appellant's representative in the case record resulted in the Appellant's representative not being notified that the Respondent required verification of the Appellant's retirement asset or that subsequently, the Appellants Medicare Premium Assistance application had been denied. The Respondent affirmed that neither a copy of the verification nor the denial notice were issued to the Appellant's representative.

Verification Requests:

The Respondent testified that even though the Appellant had an authorized representative, the Appellant "had capacity," received a copy of the written document verification request and had the responsibility to submit appropriate verification to the Respondent. The reasons for the Appellant's appointment of an authorized representative were not established during the hearing and further, this Hearing Officer holds that the Appellant's mental capacity status is irrelevant to the issue of the hearing. Although policy wording states that the primary responsibility for providing verification rests with the client, the Appellant had noticed the Respondent on her application that she wished for her authorized representative to act on her behalf. As the Respondent failed to notice the Appellant's authorized representative that document verification was required, the Appellant's authorized representative was unable to take action to meet the Appellant's responsibility to provide requested verification.

Policy provides that when it becomes clear that additional information or verification is needed, the Respondent worker must notify the client in writing of the needed information and the date by which the information must be received. No evidence was submitted to demonstrate what date the verification notice had been issued or the date by which information was to be received. The Respondent testified that even though a written copy of the verification request had not been issued to the Appellant's authorized representative, that several phone calls had occurred following the Appellant's denial in an effort to obtain the requested documentation. The Respondent testified that the Appellant's case record reflected that a phone call had occurred in August 2018 between the Respondent worker and the Appellant's representative in which the Appellant's representative had been advised that documentation of the Appellants assets was required. The Appellant's representative affirmed that the Respondent advised by telephone in August 2018 that the Appellant's application had been denied; however, the Appellant's representative denied that communication regarding the specific requested verification documents had occurred at that time. As case comments were not submitted as evidence, this Hearing Officer could not corroborate the content of the August 2018 interaction between the Respondent worker and Appellant representative.

Back-dating Coverage:

In 2019, the Appellant's representative submitted March through May 2018 bank and IRA statements to the Respondent. The Respondent testified that pursuant to receiving these documents that the Appellant was approved for Medicaid Specified Low-Income Medicare Beneficiaries (SLIMB) Medicare premium assistance benefits. The Respondent testified that the Appellant's SLIMB coverage was back-dated to December 2018 - as far as the Respondents system would permit. The Respondent testified that based on the document verification received from the

Appellant that if the verification documents had been provided at the time of application, the Appellant may have been eligible for coverage during the month of her May 2018 application. The Appellant's representative testified that the documents submitted were for March through May 2018 and as the Appellant was determined to be eligible, she should have been eligible at the time of application.

Because the Respondent failed to request verification from the Appellant's authorized representative at the time of application, an agency delay occurred. Policy provides that when verification is received and the client is determined eligible, medical coverage is retroactive to the date eligibility would have been established. Although the Respondent testified that the Respondent's computer system will not allow back-dating beyond December 2018, the Respondent has a responsibility to act according to policy requirements. As policy clarifies that when eligible, SLIMB coverage may be back-dated up to three months prior to the month of application, the Appellant's representative's request to back-date SLIMB coverage to May 2018 - the month of application – is within reason.

CONCLUSIONS OF LAW

1) Pursuant to policy, the Appellant is entitled to identify an authorized representative to act on her behalf; as such, she identified [redacted] as her authorized representative on her May 21, 2019 application for Medicare Premium Assistance.

2) The Respondent failed to reflect [redacted] as the Appellant's authorized representative in the Appellant's case record.

3) The Respondent was required to issue a written request of verification to the Appellant's representative identifying the specific documents to be submitted and date by which documents must be received.

4) Because the Respondent failed to submit a written request of verification to the Appellant's authorized representative, [redacted] was unable to act on the Appellant's behalf and submit the requested documentation.

5) The Respondent incorrectly denied the Appellant's Medicare Premium Assistance application due to failure to submit requested documentation.

6) The Respondent's failure to issue proper written request of verification documents to the Appellant's authorized representative caused an agency delay.

7) When the Respondent received the Appellant's verification and the Appellant was determined eligible for SLIMB coverage, the Respondent had a responsibility to award the Appellant medical coverage retroactive to the date eligibility would have been established pursuant to her May 2018 application.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to deny the Appellant's application for Medicare Premium Assistance due to failure to submit requested information. It is **ORDERED** that the Appellant's Medicare Premium Assistance (SLIMB) benefit is retroactively approved effective the month of application.

ENTERED this 11th day of June 2019.

_____

Tara B. Thompson
State Hearing Officer