STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH
Office of the Inspector General
Board of Review

Sherri A. Young, DO, MBA, FAAFP
Cabinet Secretary

Christopher G. Nelson
Interim Inspector General

January 25, 2024

[redacted]

RE: [redacted] v. WVDoHS
ACTION NO.: 23-BOR-3586

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 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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

Encl: Decision Recourse
Form IG-BR-29
CC: Leslie Riddle, [redacted] Department of Human Services (DoHS)

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WEST VIRGINIA DEPARTMENT OF HEALTH
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 23-BOR-3586**

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 the Inspector General's Common Chapters Manual. This fair hearing was convened on January 3, 2024.

The matter before the Hearing Officer arises from the Respondent's October 30, 2023 decision to terminate his Medicaid benefits.

At the hearing, the Respondent appeared by Leslie Riddle, [redacted] Department of Human Services (DoHS). The Appellant appeared and represented himself. All witnesses were sworn in and the following documents were admitted into evidence.

Department's Exhibits:
D-1 West Virginia Income Maintenance Manual (WVIMM) excerpts
D-2 [redacted] Premium Notice, dated September 17, 2023
D-3 [redacted] Statements, dated July 26, 2019, for [redacted]

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) The Appellant was a recipient of Medicaid Aged and Disabled Waiver (ADW) benefits and Qualified Medicare Beneficiary Coverage through November 30, 2023.

2) On October 30, 2023, the Respondent issued a notice advising the Appellant his Medicaid benefits would stop, after November 30, 2023, because the amount of assets exceeded the Medicaid eligibility limit and because he failed to return all requested proof of life insurance policy cash surrender value.

3) The Respondent's decision was based on $3,319.42 in verified liquid assets, $4,494.47 total assets, $1,210 gross unearned income, and $1,190 countable net income.

4) The Respondent's decision was based on $1,175.05 in life insurance assets.

5) On October 2, 2023, the Appellant submitted a [redacted] Premium Notice indicating a current due balance of $151.25 (Exhibit D-2).

6) On August 5, 2019, the Appellant submitted July 26, 2019 [redacted] statements. The [redacted] statement reflected a then-current death benefit life insurance policy amount of $1,402.26; a face value after the two-year limited benefit period of $5,004.00; and a then-current cash value of $196.06.

7) The July 26, 2019 [redacted] statements reflected the Appellant's [redacted] policy beneficiary designee as [redacted] (Exhibit D-3).

8) The [redacted] statement reflected a then-current face value of $6,594.00 and a cash value of $978.99 (Exhibit D-3).

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual § 501.11 *Financial Eligibility* provides in relevant parts: For Medicaid Aged and Disabled Waiver (ADW) eligibility, a client is determined eligible through the completion of a Medicaid Long-Term Care (LTC) application. If an applicant is over the income/asset guidelines, the applicant is notified of the denial of financial eligibility.

West Virginia Income Maintenance Manual (WVIMM) § 24.1 *Long-Term Care Introduction* provides in relevant sections: The policies within this section apply to both institutional care and non-institutional home and community-based services (HCBS) — including the Aged and Disabled Waiver (ADW).

WVIMM § 24.16 *Application/Redetermination* provides in relevant sections:

> If the client is not eligible for full-coverage Medicaid, he may be eligible [for] the ICF/IID group if he meets certain income and asset standards. These applicants, including QMB, must complete the full application process ….
>
> The application/redetermination process is the same as SSI-Related Medicaid, with the following exceptions.

WVIMM § 26.12.1 *Qualified Medicare Beneficiaries (QMB)* provides in relevant sections: To be eligible for QMB, assets may not exceed $9,430 for a one-person AG.

WVIMM § 23.11.1 *SSI Recipients* provides in relevant sections: To be eligible for SSI-Related Medicaid, the recipient's income cannot exceed $2,000 for a one-person AG.

Assets:

WVIMM (WVIMM) § 5.3.4 *Accessibility of Assets* provides in relevant sections:

> A client may not have access to some assets. To be considered an asset, the item must be owned by, or available to, the client and available for disposition. If the client cannot legally dispose of the item, it is not his asset.
> Examples of inaccessibility include, but are not limited to, the following: …

WVIMM § 5.4 *Maximum Allowable Assets* provides in relevant sections: To be eligible for SSI Medicaid, Aid to Families with Dependent Children (AFDC)-Related, Medicaid, PAC, and CDCSP, for a one-person Assistance Group (AG), the asset limit is $2,000. To be eligible for QMB, SLIMB, or QI-1, for a one-person AG, the asset limit is $9,430.

WVIMM § 5.5.4.A *Savings Accounts, Christmas Clubs, Checking Accounts, CDs* provides in the relevant sections:

> The current month's income deposited in accounts is not counted as an asset for that month when determining AFDC-Related and SSI Group Medicaid eligibility.

WVIMM § 5.5.27 *Life Insurance (Cash Surrender Value)* provides in relevant sections:

> SSI Medicaid Groups: If the face value of all life insurance policies for one individual totals $1,500 or less, the cash surrender values are not considered as an asset. If the face value of all life insurance policies for an individual is in excess of $1,500, the cash surrender values are counted as an asset. The life insurance policy must be owned by the client or by a person whose assets are deemed to him to be counted. If the consent of another individual is needed to surrender a policy for its full cash surrender value, and the consent cannot be obtained, the policy is not an

asset. Assignment of a life insurance policy to another individual means consent of that individual is required before it can be cashed.

WVIMM § 5.1 *Definitions* provides in relevant parts:

Beneficiary: A person to whom benefits are payable.
Cash Surrender or Cash-In Value: The amount of cash received by the owner of the policy, if redeemed before death of the insured.
Face Value: The specified amount payable on death of the insured, usually listed on the front of the policy, is the amount guaranteed and premium terms agreed upon via contract at the time of purchase.

Verification:

WVIMM § 24.2 *Verification* provides in relevant sections: Routine verification requirements are outlined in Chapter 7. Additional verification requirements for long-term care services are included in this chapter.

WVIMM § 7.2.1 *When Verification is Required* provides in relevant sections:

Verification of a client's statement is required when:

- The policy requires routine verification of specific information.
- The information provided is questionable. To be questionable, it must be: … outdated.
- The client does not know the required information

WVIMM § 7.2.3 *Client Responsibilities* provides in relevant sections:

The primary responsibility for providing verification rests with the client …. 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.

WVIMM § 7.2.4 *Worker Responsibilities* provides in relevant sections:

The Worker has the following responsibilities in the verification process:

- At … redetermination … the Worker must list all required verification known at the time.

WVIMM § 9.2.1 *DFA-6, Notice of Information Needed* provides in relevant sections:

If the client fails to adhere to the requirements detailed in the DFA-6 notice, the application is denied …. This form also notifies the client that his application will

be denied … if he fails to provide the requested information by the date specified on the form.

WVIMM § 9.2.1.C *Medicaid and WV CHIP* provides in relevant sections:

The date entered in the DFA-6 must be at least 10 days from the date of issuance or a time agreed upon with the applicant. See Due Date of Additional Information in Section 1.6.4.

WVIMM § 1.6.4 *Due Date of Additional Information* provides in relevant sections:

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

DISCUSSION

The Respondent's representative testified that the Appellant was a recipient of Medicaid QMB and LTC Aged and Disabled Waiver (ADW) benefits. Following the Appellant's submission of a Medicaid eligibility review, the Respondent determined the Appellant was ineligible for continued Medicaid because the Appellant failed to verify his amount of assets and because the Appellant's assets exceeded the Medicaid asset limit for QMB and LTC eligibility. The Respondent subsequently notified the Appellant his eligibility would be terminated after November 2023. The Appellant contended that he should be found eligible for Medicaid coverage because he requires in-home medical assistance. The Appellant argued he should be found eligible while retaining his income and assets without assigning his life insurance policy to another individual. The Appellant requested the Respondent's decision be reversed and his Medicaid benefit eligibility be reinstated.

During the hearing, the Appellant disagreed with the income and asset limits outlined in the policy. The Board of Review cannot judge the policy and can only determine if the Respondent correctly applied the policy when reviewing the Appellant's Medicaid income eligibility. The Board of Review is required to follow the policy and cannot change the policy or award eligibility beyond the circumstances provided in the policy. The Hearing Officer is unable to grant the Appellant relief by awarding Medicaid eligibility exceptions beyond the policy provisions.

Under the related COVID-19 Public Health Emergency (PHE) procedures, the Appellant received continuous Medicaid eligibility during the COVID-19 PHE. After April 1, 2023, the Respondent was permitted to resume considering all eligibility criteria determining Medicaid eligibility.

The Respondent bears the burden of proof. The Respondent had to demonstrate by a preponderance of the evidence that the Respondent requested the Appellant submit asset verification ten days before the information was due and that the Appellant failed to comply with the verification request by the specified date. Further, the Respondent had to prove that the Appellant's assets exceeded the Medicaid eligibility limit for each type of assistance.

Failure to Submit Verification

During an eligibility review, when the Respondent's worker identifies information that is unclear or outdated, the information is questionable. According to the policy, when the information provided is questionable, verification of the information is required. When seeking verification, the Respondent's notice must list all required verification and provide the Appellant with ten days to submit the information. The policy specifies that the verification due date must be at least 10 days from the date of issuance.

Failure of the client to provide necessary information or to sign authorizations for the release of information results in the closure of the active case provided the client has access to such information and is physically and mentally able to provide it.

During the hearing, the Respondent's representative testified that a verification checklist was issued to the Appellant on September 21, 2023, and required the Appellant to submit his most recent checking account and life insurance cash surrender value information by September 30, 2023. The Respondent's representative argued that the Appellant failed to submit the requested verification.

The Appellant was not able to affirm that he received a verification checklist and testified that he believed he may have but was unsure. Because the verification request was not submitted as evidence, the specific items listed on the verification request cannot be affirmed. The Appellant testified that he submitted bank statements. The Respondent's representative affirmed that bank statements were received from the Appellant on October 2, 2023; however, the statements were not provided as evidence. The Respondent's representative testified that because the Appellant's assets exceeded the Medicaid eligibility limit, evidence regarding the Appellant's income was not submitted.

The September 30, 2023, verification due date stated by the Respondent's representative fell nine days after the declared September 31, 2023 verification request issuance. Because the preponderance of the evidence failed to demonstrate that the Appellant was provided with a verification request that listed all known information to be submitted within ten days, this Hearing Officer cannot affirm that the Appellant failed to comply with the Respondent's verification request.

Assets

To be eligible for QMB, the client's assets could not exceed $9,430. To be eligible for LTC, the client's assets could not exceed $2,000.

The Respondent's representative could not clearly articulate the calculations used to determine the income and asset amounts reflected on the notice when determining the Appellant's ongoing Medicaid eligibility. The $3,319.42 of liquid assets listed on the notice was inconsistent with the amount of liquid assets the Respondent's witness testified were verified with the Appellant's October 2, 2023 bank statements. The Respondent's representative testified that the Appellant's bank statement reflected "around $3,200" in liquid assets.

During the hearing, the Respondent's representative testified that she believed that the Respondent's worker evaluated the Appellant's eligibility based on old asset verifications because the Appellant did not submit the requested verifications. The policy stipulates that unclear information must be verified and that if the client fails to comply with verification requests, the case is closed. The Respondent's redetermination of the Appellant's ongoing Medicaid QMB and LTC benefits based on outdated information was incorrect. The preponderance of the evidence failed to establish that the Appellant's assets exceeded the Medicaid asset eligibility limits for either coverage group.

CONCLUSIONS OF LAW

1) When a client fails to provide the necessary requested information, the Respondent may close the active case.

2) The Respondent must notify the Appellant of his requirement to submit verification. The verification due date must be at least 10 days from the date of the issuance of the verification request.

3) The preponderance of the evidence failed to prove that the Respondent provided the Appellant with an asset verification request that listed all requested information and provided the Appellant with 10 days to submit the information.

4) To be eligible for QMB, assets may not exceed $9,430 for a one-person AG.

5) To be eligible for SSI-Related Medicaid, the recipient's income cannot exceed $2,000 for a one-person AG.

6) The preponderance of the evidence failed to verify the amount of the Appellant's assets.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Medicaid benefits, effective November 30, 2024. The matter is **REMANDED** for issuance of a verification request that lists all known asset information needed and provides the Appellant with ten days to submit the information. The matter is **REMANDED** for a new eligibility determination based on information submitted by the Appellant in response to the properly issued verification request. The Appellant's Medicaid benefits are hereby **ORDERED** to be reinstated retroactively to the date of termination. The Appellant reserves the right to appeal any subsequent Medicaid denials.

Entered this 25th day of January 2024.

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Tara B. Thompson, MLS
State Hearing Officer