**State of West Virginia**
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**Office of Inspector General**
**Board of Review**
**2699 Park Avenue, Suite 100**
**Huntington, WV 25704**

**Joe Manchin III**
**Governor**

**Martha Yeager Walker**
**Secretary**

September 23, 2008

Building
325 Seventh Street
Parkersburg, WV 26102
Attn:

**RE: _______________**

Dear Mr. ___________:

Attached is a copy of the findings of fact and conclusions of law on your hearing held April 11, 2008. Your hearing request was based on the Department of Health and Human Resources' determination of your contribution toward your cost of care and the Community Spouse Maintenance Allowance (CSMA) for your household for Long Term Care Medicaid.

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.

Eligibility for the Long Term Care Medicaid program is based on current policy and regulations. Some of these regulations state that shelter costs used in determining the CSMA include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative. Additionally, non-reimbursable medical expenses used in determining the contribution toward cost of care must be documented by an order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law.

The information that was submitted at your hearing revealed nothing that could be used to adjust either the CSMA or the contribution toward your cost of care.

It is the decision of the State Hearing Officer to **uphold** the Department's determination of your CSMA amount and the contribution toward your cost of care.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Lisa Heater, Department Representative

**WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES**
**BOARD OF REVIEW**

**__________,**

**Claimant,**

**v.** **Action Number: 08-BOR-809**

**West Virginia Department of**
**Health and Human Resources,**

**Respondent.**

## DECISION OF STATE HEARING OFFICER

## I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on September 23, 2008 for __________. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on April 11, 2008 on a timely appeal, filed February 4, 2008.

All persons offering testimony were placed under oath.

## II. PROGRAM PURPOSE:

The program entitled Long Term Care Medicaid (nursing facility services) is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources. It is a medical service which is covered by the State's Medicaid Program. Payment for care is made to nursing homes which meet Title XIX (Medicaid) standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet financial and medical eligibility criteria.

## III. PARTICIPANTS:

__________, Claimant's wife
[redacted] Claimant's attorney
Lisa Heater, Department Representative

Presiding at the Hearing was Todd Thornton, State Hearing Officer and a member of the State Board of Review.

## IV. QUESTIONS TO BE DECIDED:

The question to be decided is whether the Department was correct in its determination of the Claimant's Community Spouse Maintenance Allowance (CSMA) and contribution toward his cost of care for Long Term Care Medicaid.

## V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual, Chapter 17.9

## VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

**Department's Exhibits**:

D-1 Hearing Request (DFA-FH-1 dated February 1, 2008)
D-2 Notification Letters: Notice of Contribution to the Cost of Care (NMNH) dated January 21, 2008 and February 22, 2008; EDR2 dated January 26, 2008
D-3 AFUI Screen Prints from RAPIDS, detailing unearned income for _____ and _____ ___________
D-4 EIRA Screen Prints (NF/ICFMR Patient Liability) from RAPIDS; AFSC Screen Prints (Shelter Costs) from RAPIDS; AFUC Screen Prints (Utility Costs) from RAPIDS; Long-Term Care Post-Eligibility Calculations form (IM-NL-LTC-1)
D-5 West Virginia Income Maintenance Manual, Chapter 17.9 and Chapter 10, Appendix A
D-6 CSMA calculation sheet

**Claimants' Exhibits:**

C-1 List of monthly household expenses

## VII. FINDINGS OF FACT:

1) On or about January 21, 2008, the Claimant – an active recipient of Long-Term Care Medicaid through the Department – was issued notification advising of the contribution to the cost of care and the Community Spouse Maintenance Allowance (CSMA). The notification states that the prorated contribution amount for December 2007 is $329.00, the full month amount starting in January 2008 is $779.10 per month, and the CSMA – noted in additional comments – is $623.70 per month (Exhibit D-2).

2) The Claimant submitted a Fair Hearing Request on February 1, 2008 (Exhibit D-1). A subsequent notification letter was sent by the Department to the Claimant on or about February 22, 2008 advising that the contribution amount changed to $820.00 per month starting in March 2008 (Exhibit D-2).

3) The West Virginia Income Maintenance Manual, Chapter 17.9, D (Exhibit D-5), explains the process for determining the CSMA and the Claimant's contribution toward his cost of nursing facility care as follows:

D. POST-ELIGIBILITY PROCESS

In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care.

**NOTE:** The Economic Stimulus Tax Rebate for 2007 is excluded as income in post-eligibility calculations.

The client's spenddown amount, if any, as determined in item C,4 above, is added to this amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the cost of care to determine eligibility. See item 2 below.

1. Income Disregards And Deductions

Only the following may be deducted from the client's gross, non-excluded income in the post-eligibility process:

a. Personal Needs Allowance

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. The monthly amount deducted is $50. However, for an individual who is entitled to the reduced VA pension of $90, the monthly Personal Needs Allowance is $90.

b. Community Spouse Maintenance Allowance (CSMA)

When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home.

To determine the CSMA, the income of the community spouse is subtracted from a Spousal Maintenance Standard (SMS) which is either:

- The minimum SMS. This is 150% of the monthly FPL for 2 persons; or

- The minimum SMS, increased by excess shelter/utility expenses, but not exceeding the maximum SMS.

See Chapter 10, Appendix A for the minimum and maximum Spousal Maintenance Standard amounts.

The remainder is the amount of the institutionalized spouse’s income which can be used to meet his community spouse’s needs.

The determined amount must actually be paid to the community spouse for the deduction to be applied. If the client contributes less than the determined amount, only the amount actually contributed to the community spouse is deducted. If he has been ordered by a court or a Hearings Officer to contribute more to his spouse, the higher amount is deducted.

The following steps are used to determine the amount of the CSMA.

Step 1: Add together the actual shelter cost and the amount of the current Food Stamp Heating/Cooling Standard (HCS). See Chapter 10, Appendix B. The shelter cost must be from the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.

Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS. See Chapter 10, Appendix A. When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs.

Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. See Chapter 10, Appendix A.

Step 4: Add together the community spouse's gross, non-excluded earned and unearned income.

Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse.

If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed.

**NOTE:** The amount used from Step 3 cannot exceed the maximum SMS.

c. Family Maintenance Allowance (FMA)

When the institutionalized individual has family members who are living with the community spouse and who are financially dependent upon him, an FMA is deducted from his income. This amount is deducted whether or not the individual actually provides the money to the family members. For purposes of this deduction, family members are the following people only: minor or dependent children, dependent parents of either spouse

and dependent siblings of either spouse. This deduction is applied only when the institutionalized individual has a community spouse, and such family members live with the community spouse.

The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross non-excluded income from the minimum SMS. See Chapter 10, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.
Step 2: Divide the remaining amount by 3, and round the resulting amount up.

**EXAMPLE:** $201.07 = $202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

**NOTE:** The FMA for each family member must not exceed one-third of the minimum SMS. See Chapter 10, Appendix A.

d. Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within 6 months. The amount may be deducted for up to 6 months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible, only as determined in items C,2, 3 or 4 above, certain medical expenses which are not reimbursable may be deducted in the post-eligibility process. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income. When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non-reimbursable from another source may be used as a deduction. Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare,

Medicaid, private insurance or another individual. The incurred expense must be the responsibility of the client.

The total of all non-reimbursable medical expenses is entered in RAPIDS. The total amount is not rounded.

**NOTE:** For all AG's except those with a community spouse, the amount of the client's spenddown, if any, which was calculated during the eligibility determination process, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have

(1) Time Limits and Verification Requirements for Expenses

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the 3 months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources.

**EXCEPTION:** A deduction may be given if there is evidence of a payment in the 3 months prior to application, even when the expense was incurred prior to that time.

**EXAMPLE:** Mrs. C applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the 3-month period, since there is evidence of a payment in the 3 months prior to application.

**EXAMPLE:** Same situation as above, except that Mrs. C did not make any payments during July, August or September. Since she did not incur the expense in the 3 months prior to the month of application or the month of application and made no payments during the 3-month period, no deduction is given.

The request for consideration of a non-reimbursable medical expense must be submitted within 1 year of the date of service(s).

Documentation must consist of the following:

- An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and

- An itemization of the services provided.

(2) Additional Limits for Expenses

For the items or services listed below, the following limits apply:

- Eye examination and eyeglasses - $300 in a 12-month period

- Eyeglasses - 2 pair in a 12-month period, unless medical necessity is established. The $300 limit in a 12-month period applies.

- Dentures - $3,000 in a 12-month period, unless medical necessity is established

- Hearing Aids - $1,500 in a 12-month period, unless medical necessity is established

**NOTE:** Medical necessity is determined by the Worker and/or Supervisor, based upon the documentation provided.

(3) Expenses Which Cannot Be Used

The following expenses cannot be used as a deduction for non-reimbursable medical.

- Durable medical equipment, unless purchased by the client prior to Medicaid payment for nursing facility services, and the cost was not reimbursable from any source

- Bills for non-payment of the client contribution after Medicaid eligibility for nursing facility services is approved

- Medical expenses incurred during a period of Medicaid eligibility which are covered by Medicaid

- Nursing facility expenses incurred during a period of Medicaid ineligibility for excess assets, when the reason for excess assets is non-payment of the client contribution

- Co-insurance payments while the individual is Medicaid eligible and has Medicare or private health insurance

- Charges for an ambulance or transportation which is medically necessary for an individual in a nursing facility who is Medicaid and/or Medicare eligible or has private insurance

- Charges incurred during temporary periods of Medicaid ineligibility when the reason is failure to complete a redetermination and the AG is subsequently reopened with no break in eligibility periods

- Nursing facility charges when the reason for Medicaid ineligibility is the facility’s failure to obtain an approved PAS-2000

- Charges for bedhold days

**NOTE:** When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill from a nursing facility, a detailed itemization of the services must be provided. The itemization must include the date of the service or expense, the specific medical service, the reason no payment was received by the facility and the amount of the expense. Charges billed to Medicare, Medicaid or private insurance must be accompanied by an explanation of benefits (EOB) to be considered. Only charges denied because they are not covered services may be used.

2. Determining The Client's Total Contribution

Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care.

**NOTE:** When the client has a community spouse, the spenddown amount is not part of his contribution to his cost of care.

This amount is added to the resource amount determined in item 1 above to determine the client’s total monthly contribution toward the cost of his nursing care.

If the client is Medicaid eligible without a spenddown according to items C,2 and C,3 above, the resource amount from item 1 is his total cost contribution.

When the client resides in more than one nursing care facility during the same calendar month, the Worker must determine the portion of the client's cost contribution which must be paid to each facility. The Worker follows the steps below to determine how much of the client's total contribution must be paid to the first facility he entered. If the client's total contribution must be paid to the first facility, no additional calculation is required. If not, the amount(s) paid to the other(s) is determined in the same way. The ES-NH-3 is used for notification of the amount due each facility.

Step 1: Determine the client's monthly contribution toward his cost of care.

Step 2: Multiply the number of days the client was in the first facility by the per diem rate for the facility. The result is the clients cost of care for this facility for the month.

Step 3: Compare Step 1 to Step 2.

If Step 1 is less than or equal to Step 2, the client's entire contribution toward his cost of care is paid to the first facility.

If Step 1 is greater than Step 2, the Step 2 amount is paid to the first facility and the difference between Step 1 and Step 2 is paid to the second facility.

4) The Department also submitted West Virginia Income Maintenance Manual, Chapter 10, Appendix A (Exhibit D-5), which showed minimum and maximum Spousal Maintenance Standard (SMS) amounts as $1712.00 and $2610.00, respectively. West Virginia Income Maintenance Manual, Chapter 10, Appendix B lists a Food Stamp Heating/Cooling Standard (HCS) amount of $366.00.

5) The Department demonstrated how they followed the five-step process outlined in Exhibit D-5 to arrive at a CSMA amount of $623.70 (Exhibit D-6). Monthly shelter costs of $54.16 and $50.76 listed in Exhibit D-4 were added to the HCS amount of $366.00 to arrive at a $470.94 amount in Step 1. In Step 2, the minimum SMS amount of $1712.00 was multiplied by 30% to arrive at an amount of $513.60. Because the amount in Step 1 is less than the amount in Step 2, the remainder amount is zero. Because this remainder amount is zero, the amount in Step 3 is the $1712.00 minimum SMS amount. Step 4 was a total of the monthly unearned income amounts for the Claimant's wife of $642.50 and $445.80, or $1088.30 (Exhibit D-3). The final CSMA amount is determined in Step 5 by subtracting the Step 4 amount ($1088.30) from the Step 3 amount ($1712.00), or $623.70.

6) The Department further explained the process for determining the resource amount from the CSMA amount (Exhibit D-4). The monthly unearned income amounts of the institutionalized spouse (Exhibit D-3) were $1292.50 and $253.80, for a total of $1546.30. From this total, a Personal Needs Allowance of $50.00, the CSMA of $623.70, and the Medicare Premium of $93.50 were subtracted, leaving a $779.10 resource amount. The Department's testimony provided the Medicare Premium amount. For a household with a community spouse, the resource amount is the same as the Claimant's contribution toward his cost of care.

7) A listing of monthly expenses for the Claimant's wife – the community spouse – was provided (Exhibit C-1). The Department stated that the shelter expenses reflected an increase in the Homeowner's Insurance monthly amount from $50.78 to $62.86, and a $10.00 monthly expense for a Homeowner's Association fee not previously considered by the Department. After adjusting for these changes, the amount in Step 1 of FOF #5 would change to $493.02; however, this amount still would not exceed the $513.60 threshold in Step 2, and would make no change in the end result for either the CSMA or the Claimant's contribution toward his cost of care.

8) Testimony from the Department conceded no other expenses from Exhibit C-1 that could be used to reconsider the CSMA amount. Medical expenses itemized in Exhibit C-1 were for the Claimant's spouse, and the Department explained that they could not be used unless they were for the Claimant. An expense for adult diapers for the Claimant was noted on the Claimant's behalf.

## VIII. CONCLUSIONS OF LAW:

1) The West Virginia Income Maintenance Manual, Chapter 17.9, D states, with regard to allowable shelter costs in determining the CSMA, in pertinent part:

> The shelter cost must be from the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.

An adjustment was made to the shelter costs of the Claimant's household, but this made no change to the end result in the CSMA amount. Testimony from the Department and policy revealed no other costs that could be used to change the CSMA.

2) The Claimant's contribution toward his cost of care additionally could have been changed by a change in non-reimbursable medical expenses. The expense for adult diapers for the Claimant was mentioned as a possible expense in this area. The West Virginia Income Maintenance Manual, Chapter 17.9, D states, with regard to verification requirements for non-reimbursable medical expenses, in pertinent part:

> Documentation must consist of the following:
>
> - An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and
>
> - An itemization of the services provided.

Evidence did not document the medical necessity of this expense. It cannot, therefore, be considered in the calculation of the Claimant's contribution toward his cost of care.

3) The Department demonstrated that their calculation of the CSMA and the Claimant's contribution toward his cost of care was thorough and correct. The expenses listed for the Claimant's spouse either did not meet the eligibility requirements to be considered, or did not affect the results at the end of the calculation process.

## IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's determination of the Claimant's contribution toward his cost of care and the CSMA for his household.

## X. RIGHT OF APPEAL:

See Attachment

## XI. ATTACHMENTS:

The Claimant’s Recourse to Hearing Decision

Form IG-BR-29

**ENTERED this _____ Day of September, 2008.**

______________________________________

**Todd Thornton**
**State Hearing Officer**