STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
Board of Review
4190 West Washington Street
Charleston, West Virginia 25313
Email: raywoods@wvdhhr.org

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

March 16, 2005

_____
_____
_____

Dear Mr. _____;

Attached is a copy of the findings of fact and conclusions of law on your hearing held December 10, 2004. Your hearing request was based on the Department of Health and Human Resources' action to require a spenddown of your resources.

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 and benefit levels for SSI-Related Medical Assistance Only are determined based on current regulations. One of these regulations specifies that:

"To receive a Medicaid card, the Income Group's monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are subtracted from the income for the 6-month POC, until the income is at or below the MNIL for the Needs Group size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid. (West Virginia Income Maintenance Manual Section 10.21 (D) (11) Spenddown).

The information submitted at the hearing revealed: You did not have any medical expenses to meet the required spenddown.

It is the decision of the State Hearing Officer, to uphold the action of the Department to deny application for Medicaid Benefits.

Sincerely,

Ray B. Woods, Jr., M. L. S.
State Hearing Officer
Member, State Board of Review

cc: State Board of Review
Alice Crabtree, ESW – [redacted] County DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

NAME: _____

ADDRESS: _____

SUMMARY AND DECISION OF THE STATE HEARING OFFICER

I. INTRODUCTION

This is a report of the State Hearing Officer resulting from a fair hearing concluded on March 16, 2005 for Mr. _____.

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 December 10, 2004 on a timely appeal filed November 3, 2004.

It should be noted here that Mr. _____ was not receiving SSI-Related Medical Assistance Only Benefits at the time of the Fair Hearing.

All persons giving testimony were placed under oath. This issue could not be resolved in a pre-hearing conference.

II. PROGRAM PURPOSE

The program entitled SSI-Related Medical Assistance Only is set up cooperatively between the Federal and State Government and administered by the West Virginia Department of Health and Human Resources.

SSI Related Medicaid is a segment of the Medicaid Program available to individuals who meet the requirement of categorical relatedness by qualifying as aged, disabled, or blind as those terms are defined by the Social Security Administration for purposes of eligibility for SSI.

III. PARTICIPANTS

_____, Claimant
Alice Crabtree, Economic Services Worker [redacted] County DHHR

Presiding at the hearing was, Ray B. Woods, Jr., M. L. S., State Hearing Officer and; a Member of the State Board of Review

IV. QUESTION(S) TO BE DECIDED

Does Mr. _____ have a spenddown for the Medicaid Program?

V. APPLICABLE POLICY

West Virginia Income Maintenance Manual Chapter 10.21 (D) (11) Spenddown:

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED

D-1 IG-BR-40 Hearing Notice
D-2 IG-BR-29 DHHR Hearing/Grievance Record Information
D-3 Chapter 10.21.D.11, 1.21.H from DHHR Manual
D-4 Denial letters dated October 19, 2004 and July 9, 2004.
D-5 Case Comments
D-6 Medical bills from [redacted] General Hospital
D-7 Letter from [redacted] General Hospital dated 12/15/04

VII. FINDINGS OF FACT

- Ms. Crabtree submitted the following Hearing Summary:

Client applied for food stamps and medicaid on September 17, 2004.

Spenddown letter was given to client requesting medical bills. Medical bills were received in the office on October 20, 2004. Medical had been denied and client was sent a letter on October 19, 2004.

The bill in question was from [redacted] General Hospital in the amount of $5473.51. called DHHR Hospital Worker at [redacted] General on October 29 and was advised that the bill was written off to charity and that he did not owe this bill. She provided me with a printout of another bill stating that he owes $1060.22 which is not enough to meet the spenddown amount of $3961.62.

Client was denied twice for a spenddown medical card - dates of July 9, 2004 and October 19, 2004 due to not having unpaid medical bills.

Client requested hearing and IG-BR-29 was sent to Hearing Officer on October 28, 2004.

- [redacted] General Hospital submitted a letter to the Department dated December 15, 2004. It stated in part, “The two accounts totaling $228.75 and $5,473.51, respectively, were written off to charity.”

- Mr. _____ did not have any medical expenses to meet the spenddown for Medicaid Benefits.

VIII. CONCLUSIONS OF LAW

- **West Virginia Income Maintenance Manual Chapter 10.21 (D) (11) Spenddown:**

To receive a Medicaid card, the Income Group's monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are

subtracted from the income for the 6-month POC, until the income is at or below the MNIL for the Needs Group size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid.

a. Procedures

The Worker must determine the amount of the client's spenddown at the time of application based on information provided by the client. The spenddown amount may have to be revised if the verified income amount differs from the client's statement. He must also explain the spenddown process to the client during the intake interview. An ES-6A is attached to the ES-6 which notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses. The RAPIDS verification checklist includes the ES-6 information when RAPIDS detects a spenddown AG. The verification checklist or ES-6 must also contain any other information the client must supply in order to determine eligibility.

Once the client presents sufficient medical expenses to meet his spenddown obligation and all other Medicaid eligibility requirements are met, appropriate RAPIDS procedures are followed to approve the AG and enter the spenddown.

NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated on Screen AGTM, are not paid by Medicaid.

NOTE: An AG which meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individuals is an AG member.

- A member(s) of the Income Group experiences an increase in income; or

- An individual(s) with income is added to the Income Group; or

- An individual(s) is removed from the Needs Group

The following procedures are required to accomplish the spenddown process.

- The Worker prepares the verification checklist or ES-6, attaches an ES-6A and gives them to the client during the intake interview or mails them after the interview.

  If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally or emotionally unable to verify his medical expenses.

- The client is requested to provide proof of his medical expenses, date incurred, type of expense and amount and to submit them to the Worker by the application processing deadline.

- When the bills or verification are received, the Worker reviews them to determine:

  - The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.

    NOTE: Prescription drugs purchased with the Medicare-approved discount drug card and those covered by the $600 per year Transitional Assistance credit are not considered reimbursed by a 3rd party. See item c below.

  - The individual(s) who received the medical service is one of the people described in item b. below.

  - The expenses are for medical services and are appropriate to use to meet a spenddown. See item c. below.

- The Worker must enter the pertinent information about expenses received from the client on Screen AGTM.

  - The date of service

  - The provider of the service

  - The total amount of the bill

  - The third-party liability amount

- Medical Processing in BMS accesses RAPIDS Screen AGTM to determine the date on which spenddown is met. Additional notification is required only when a change is necessary to add additional medical expenses after the spenddown is met and will result in an earlier POE. In this instance the Worker must use form IM-MS-1 and highlight or circle in red the bill which meets the client's spenddown. A copy is sent to Medical Processing in BMS and a copy is filed in the case record. The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

  NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated on Screen AGTM, are not paid by Medicaid.

- If the client does not submit sufficient medical bills by the application processing deadline, the application is denied.

  The application is automatically denied by RAPIDS when the applicant indicates there are no medical bills or anticipated medical expenses in the 30-day application period which may be used to meet the spenddown for the Medicaid AG member(s). This is indicated by the Worker on RAPIDS Screen AGMS.

b. Whose Medical Expenses Are Used

The medical bills of the following persons who live with the AG member(s) are used to meet the spenddown. There is no limit on the amount of one individual's bills which can be used to meet another individual's spenddown.

NOTE: The past medical bills of any of the individuals listed below which were incurred while the individual lived with an AG member(s) may be used for spenddown, even if the individual no longer lives with the AG member, is deceased or is divorced from the AG member. The AG member must be responsible for the bill at the time it was incurred and remain responsible for payment.

(1) Meeting the Spenddown of Adults

Use the bills of:

- The adult(s) who is the parent(s) or other caretaker relative
- The spouse of the parent or other caretaker relative
- The dependent children of the parent or other caretaker relative
- The dependent children of the spouse of the parent or other caretaker relative
- The blood-related siblings of the children of the parent, of the children of the other caretaker relative, of the children of the spouse of the parent and of the children of the spouse of the other caretaker relative

(2) Meeting the Spenddown of Children

Use the bills of:

- The child
- The parent(s). Do not use the bills of the caretaker relative other than a parent.
- The stepparent
- The blood-related siblings of the child
- The dependent children of the stepparent and their blood-related siblings in the home.

Because the individuals whose medical expenses are used to meet a spenddown may be in separate AG's, the same medical bill is used to meet the spenddown in each AG containing one of the persons identified above.

EXAMPLE: A mother and her two children apply for Medicaid. Also in the home is the mother's husband, who is the stepfather of the children. His medical bills are used to meet the spenddown of his wife and of both children.

EXAMPLE: A mother applies for Medicaid for herself and her two children. Also in the home are her husband and his two children, who are also applying for Medicaid. The medical bills of the husband and his children are used to meet the spenddowns of his wife and stepchildren as well as his own and his children's spenddown.

EXAMPLE: Same situation as above, except that the husband and his children are not applying for Medicaid. The medical bills of the husband and his children are used to meet the spenddown of the mother and her children.

EXAMPLE: A man and woman live together, but are not married. They each have two children from previous marriages, and all are applying for Medicaid. The medical bills of the woman and her two children are used to meet their own spenddowns, but not those of the man and his two children. The medical bills of the man and his two children are used to meet their own spenddowns, but not those of the woman and her two children.

c. Allowable Spenddown Expenses

The following medical expenses, which are not subject to payment by a third-party, and for which the client will not be reimbursed, are used to reduce or eliminate the spenddown.

- A current payment on or the unpaid balance of an old bill, incurred outside the current POC, is used as long as that portion of the bill was not used in a previous POC during which the client became eligible. No payment or part of a bill which is used to make a client eligible may be used again. Old unpaid bills, which are being collected by an agency other than the medical provider, may be used when the expense is still owed to the provider. If the expense has been written off by the provider, it is no longer considered the client's obligation, and is, therefore, not an allowable spenddown expense.

  Medical bills that were previously submitted, but were not sufficient to meet the spenddown, are used again in a new POC. However, when any old or new bill is used and the spenddown is met, those same bills must not be used again in a new POC. When only a portion of the old bill, incurred outside the current POC, is used to meet spenddown, any remaining portion of the bill for which the client is still liable may be used to meet spenddown in a new POC.

  In addition, when the client submits an old bill and then withdraws his application, the old bill may be used again if he reapplies.

- Health insurance premiums, including Medicare or the enrollment fee for a Medicare-approved drug discount card

- Medicare co-insurance, deductibles and enrollment fees

- Necessary medical or remedial care expenses. This includes, but is not limited to:

  - Office visits to a physician
  - Hospital services, inpatient and outpatient
  - Emergency room services
  - Prescriptions: Prescription drugs purchased with the Medicare-approved discount drug card and those covered by the $600 per year Transitional Assistance credit are not considered reimbursed by a 3rd party. The amount used for spenddown is the cost of the prescription the individual would pay if he were not enrolled in the Medicare-approved discount drug program. This applies whether or not the individual receives the $600 Transitional Assistance. If the Worker is unable to determine the actual pre-discount price of a prescription, the amount of $48.17 per prescription is used.

    NOTE: This does not apply to prescriptions purchased with any other drug discount cards.

  - Over-the-counter drugs prescribed by a physician
  - Eye examinations
  - Eye glasses
  - Dental services
  - Therapy prescribed by a physician
  - Chiropractic services
  - Prosthetic devices
  - Durable medical equipment prescribed by a physician
  - Rental of sickroom supplies
  - Cost of in-home care
  - Services of other licensed practitioners of the healing arts, such as podiatry.

  Do not deduct any expenses which are included in a package of services, prior to the date services are rendered, such as, charges for prenatal care and delivery services or orthodontia.

- Necessary medical and remedial services which are covered services under Medicaid.

- Expenses for personal care services defined as: services provided in a client's home which are prescribed by a physician, delivered in accordance with a plan of treatment and provided by a qualified person who is not a member of the client's family, under the supervision of a registered nurse. For these purposes, home is defined as the client's full time residence, but does not include a hospital, nursing facility, intermediate care facility or any other setting in which nursing services are, or could be, made available.
  Family member for these purposes is defined as:

- A spouse
- A parent or stepparent of a minor child
- A parent of an adult child
- An adopted child or adoptive parent of a recipient
- An adult sibling or step-sibling of a minor child
- An adult sibling residing with an adult sibling recipient
- An adult child of an adult recipient.

The services must fall into any of the following general groups. Each general group shown below is further defined by examples, but is not limited to only the examples shown.

- Personal Hygiene/Grooming: care of hair, nails, teeth, mouth; shaving; bathing; toilet assistance; dressing; laundry, when related to incontinence.

- Non-Technical Physical Assistance: routine bodily functions; routine skin care, including application of non-prescription skin care products; change of simple dressings; repositioning or transferring into and out of bed, on and off seats; walking, with or without equipment; assist in administration of medication; following directions of a professional for use of medical supplies.

- Nutritional Support: meal preparation; feeding; assisting with special nutritional needs, including preparation of special formulas, prescribed feedings or special diets.

- Environmental: housecleaning, dusting and vacuuming; laundry; ironing and mending; making and changing beds; dishwashing; food shopping; payment of bills; essential errands; activities and transportation necessary to move the client from place to place; other similar activities of daily living.

Expenses billed to the client for the personal care services shown above must, at a minimum, specify the amount billed for each general group of services.

Under no circumstances are ongoing or one-time-only medical expenses to be projected. They must be used no earlier than actually incurred. Those persons who are billed for their care at intervals longer than monthly are to have the expenses used to meet spenddown on the date services are performed, not on the date billed. Such expenses are not incurred prior to receipt of services.

VIII. DECISION

It is the decision of this State Hearing Officer, to uphold the action of the Department in this particular matter. Mr. _____ did not have any medical expenses to meet his spenddown for the Medicaid Program. The expenses he incurred at [redacted] General Hospital were written off to charity.

The Department's action was proper and correct.

IX. RIGHT OF APPEAL

See Attachment.

X. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.