State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
4190 Washington Street West
Charleston, WV 25313

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

September 19, 2005

_____
_____
_____

Dear Mr. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 15, 2005. Your hearing request was based on the Department of Health and Human Resources' proposal to close your SSI-Related Medicaid case.

In arriving at a decision, the State Hearings 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 Medicaid Program is based on current policy and regulations. Some of these regulations state as follows:

To receive a Medicaid card, the monthly countable income of the Needs Group must not exceed the amount of the MNIL. If the income of the Needs Group exceeds the MNIL, the client has an opportunity to spend his income down to the MNIL by incurring medical expenses. These expenses are subtracted from the client's income for the 6-month Period of Consideration (POC), until his income is at or below the MNIL for the Needs Group until the POC expires. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid. (West Virginia Income Maintenance Manual 10.22 D (11) Spenddown).

The information submitted at your hearing revealed: You do not have enough medical expenses to meet the spenddown.

It is the decision of the State Hearings Officer to uphold the proposal of the Department to close your SSI-Related Medicaid case.

Sincerely,

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

cc: Erika H. Young, Chairman, Board of Review
Patrick McKinney, Supervisor

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: _____**

West Virginia Department of Health and Human Resources,

Respondent.

DECISION OF THE STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on September 19, 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 scheduled for July 15, 2005, on a timely appeal by the Claimant on May 25, 2005.

It should be noted here that the Claimant's benefits were reinstated during the fair hearing process. A pre-hearing conference was held between the parties and, Mr. _____ did not have legal representation.

II. PROGRAM PURPOSE:

The Program entitled SSI-Related Medicaid is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

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

III. PARTICIPANTS:

_____, Claimant
Patrick McKinney, Economic Service Supervisor - [redacted] District DHHR Office

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. QUESTIONS TO BE DECIDED:

The question(s) to be decided: Did Mr. _____ have sufficient medical expenses to meet his spenddown?

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual 1.22 N (2) - REDETERMINATION SCHEDULE; West Virginia Income Maintenance Manual 1.22 R (2) – SPENDDOWN CASES; West Virginia Income Maintenance Manual 10.22 D (11) (b) WHOSE MEDICAL EXPENSES ARE USED and; West Virginia Income Maintenance Manual 10.22 D (11) (c) ALLOWABLE SPENDDOWN EXPENSES

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Department Summary
D-2 Notice of Decision dated 04/18/05
D-3 Copy of Income Maintenance Policy Manual 1.22 N (2) – REDERMINATION SCHEDULE
D-4 Copy of Income Maintenance Policy Manual 1.22 R (2) – SPENDDOWN CASES
D-5 Copy of Income Maintenance Policy Manual 10.22 D (11) (b) – WHOSE MEDICAL EXPENSES ARE USED
D-6 Copy of Income Maintenance Policy Manual 10.22 D (11 (c) – ALLOWABLE SPENDDOWN EXPENSES

Claimants' Exhibits:

C-1 None

VII. FINDINGS OF FACT:

1) West Virginia Income Maintenance Manual 1.22 N (2) - REDETERMINATION SCHEDULE:

1. Non-Spenddown

Non-Spenddown AG's are redetermined in the 6th month of the POC. The 6-month period begins with the month of application. The date of the next redetermination is automatically coded in the data system.

2. Spenddown

Spenddown AG's are not redetermined and are closed at the end of the 6th month of the POC. The client must reapply for a new POC. The last month of the 6-month POC is coded in the data system

2) West Virginia Income Maintenance Manual 1.22 R (2) – SPENDDOWN CASES:

a. The Redetermination List

There is no redetermination list.

b. The Date of the Redetermination

Applicants may come into the office at any time to reapply for a new POC.

c. Scheduling the Redetermination

These AG's are not scheduled for a redetermination. The client must apply for a new POC.

d. Client Notification

Spenddown AG's receive a computer-generated letter at the end of the 5th month of the POC. This letter informs the client that his eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

3) West Virginia Income Maintenance Manual 10.22 D (11) Spenddown

To receive a Medicaid card, the monthly countable income of the Needs Group must not exceed the amount of the MNIL. If the income of the Needs Group exceeds the MNIL, the client has an opportunity to spend his income down to the MNIL by incurring medical expenses. These expenses are subtracted from the client's income for the 6-month Period of Consideration (POC), until his income is at or below the MNIL for the Needs Group until the POC expires. 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 verification checklist or 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 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 that medical bills 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.
The following procedures are required to accomplish the spenddown process.

- The Worker prepares the verification checklist or an 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 that:

  - 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 services 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 the Screen AGTM. This includes, but is not limited to, the following:

  - The date of service

  - The provider of the service

  - The total amount of the bill

- The third-party liability amount.

- Medicaid Processing in BMS accesses RAPIDS Screen AGTM to determine the date on which spenddown is met. 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 that medical bills 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.

b. Whose Medical Expenses Are Used

The medical bills of the following persons 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 lies with the AG member, is deceased or is divorced from the AG member.

- The aged, blind or disabled individual

- The spouse of the eligible individual who lives with him

- The children under age 18 of the eligible individual and spouse, when the children live in the home with them.

The AG member must be responsible for the bill at the time it was incurred and remain responsible for payment.

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.

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, may be 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 discount drug 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, i.e., 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 or 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.

  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

    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.

2) Mr. McKinney submitted the following Hearing Summary:

On 04/18/05 Mr. _____ received a closure letter telling him that his Medicaid would close due to his period of consideration ending. Mr. _____ requested a hearing because he cannot meet another spenddown. He stated he does not have bills that he is responsible for. He stated that the bills he was responsible for are now in the courts due to bankruptcy, therefore he is no longer responsible for payment.

The Agency followed the policy found in Chapters 1.22N; 1.22R, 10.22b and; 10.22c of the West Virginia Income Maintenance Manual.

3) Mr. _____ did not have any questions for Mr. McKinney. Mr. _____ felt the policy is applied unfairly to those in need of services.

VIII. CONCLUSIONS OF LAW:

Mr. _____ did not have medical expenses to meet a spenddown. The Department's proposal to close the SSI-Related Medicaid case is proper and correct.

IX. DECISION:

It is the decision of this State Hearing Officer to uphold the Department's proposal in this particular matter.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 19th Day of September, 2005.

_____

Ray B. Woods, Jr., M.L.S.
State Hearing Officer