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

Bob Wise
Governor

Paul Nusbaum
Secretary

January 11, 2005

Case Name:

Dear Mr.

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 19, 2004. Your hearing request was based on the Department of Health and Human Resources action to deny Spousal Support as an allowable deduction.

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 Nursing Home Care are determined based on current regulations. One of these regulations specifies in part:

"Only the following may be excluded from income from the client's gross, non-excluded income in the post eligibility process: Personal Needs Allowance; Community Spouse Maintenance Allowance (CSMA); Family Maintenance Allowance (FMA); Outside Living Expenses (OLE) and; Non-Reimbursable Medical Expenses." (West Virginia Income Maintenance Manual Chapter 17.9 D POST ELIGIBILITY PROCESS).

The information submitted at the hearing revealed: The resource amount paid to the nursing home is more than the amount received from Social Security. The policy does not allow Spousal Support for ex-wives as an allowable deduction.

It is the decision of the State Hearing Officer, to uphold the action of the Department to determine allowable deductions for the Nursing Home Care Program.

Sincerely,

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

cc: State Board of Review
Cheryl Turnes, ESW

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 January 11, 2005 for Mr. on behalf of his father, 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 originally convened on October 19, 2004 on a timely appeal filed August 19, 2004.

It should be noted here that, Mr. was receiving nursing home services 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 Nursing Home Care is set up cooperatively between the Federal and State Government and administered by the West Virginia Department of Health and Human Resources.

Nursing Home Care 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

, Son/Power of Attorney
, Spouse
Phyllis Jarvis, Legal Aid of West Virginia Long Term Ombudsman (Observing)
Cheryl Turnes, Economic Service Worker – Kanawha DHHR Nursing Home Unit

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

Is Spousal Support an allowable deduction for the Nursing Home Care Program?

V. APPLICABLE POLICY

West Virginia Income Maintenance Manual Chapter 17.9 D POST ELIGIBILITY PROCESS

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED

D-1 Notice of Contribution to the Cost of Care dated 07/26/04
D-2 SSA Benefit Details Printout dated 08/14/04
D-3 WV State Online Query – RSDI Information Response Printout dated 08/17/04
D-4 West Virginia Income Maintenance Manual Chapter 17.9 D POST ELIGIBILITY PROCESS
D-5 IG-BR-40 (Scheduling Notice) dated 08/23/04

VII. FINDINGS OF FACT

- The resource amount paid to Cedar Ridge Nursing Facility is more than the amount Mr. receives from the Social Security Administration. The Social Security Administration withholds $300.00 from Mr. Benefits for Spousal Support each month.

- A Divorce was final in 1998. The Order for Spousal Support was effective October 1999. Mr. began receiving Nursing Home Medicaid in July 2004.

- Ms. Turnes reviewed the policy under WEST VIRGINIA INCOME MAINTENACE MANUAL CHAPTER 17.9 D *POST-ELIGIBILITY PROCESS*. Alimony payments (Spousal Support) are not an allowable deduction for the Nursing Home Care Program.

- According to Mr. , Social Security approved $1,296.00 - $66.00 (Medicare Premium) - $50.00 (Personal Needs Allowance) - $214.00 (Medicare Supplement Policy) = $966.00 (Resource Amount). As of August 1, 2004, the actual check received from the Social Security Administration was $930.00 due to the withholding of Spousal Support in the amount of $300.00.

- Mr. was apparently told by the Bureau of Child Support Enforcement that the only person who could rescind the Order would be the former spouse. Mr. is seeking an exception to the policy.

- The State Hearing Officer advised the parties at the conclusion of the hearing that the Department's actions appear to be correct. A review of the Medicaid Regulations will determine if the decision will change.

- Ms. Phyllis Jarvis expressed concern over similar cases in her caseload.

VIII. CONCLUSIONS OF LAW

WEST VIRGINIA INCOME MAINTENACE MANUAL CHAPTER 17.9 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. The client's spend down 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 spend down is not added to the computed resource amount. The spend down 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 SUA. 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, nonexcluded 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 nonexcluded 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.

All non-reimbursable medical expenses are totaled and any cents rounded up.

NOTE: For all AG's except those with a community spouse, the amount of the client's spend down, if any, which was calculated during the eligibility determination process, is treated as a nonreimbursable 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.

IX. DECISION

In reviewing Title 45 of the Code of Federal Regulations, State's are given the latitude to establish their own policies within the federal framework. As such, the policy found in WEST VIRGINIA INCOME MAINTENACE MANUAL CHAPTER 17.9 D - POST-ELIGIBILITY PROCESS does not list Spousal Support for ex-wives as an allowable deduction.

I have not discovered any new information that would change the decision given at the conclusion of the hearing on October 19, 2004. The Department's action in this particular matter was proper and correct.

X. RIGHT OF APPEAL

See Attachment.

XI. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.