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

October 19, 2005

_____
_____
_____

Dear Mr. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 28, 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 must spend your income down to the MNIL by incurring medical expenses to be eligible for the SSI-Related Medicaid Program.

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: 05-BOR-6116**

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 October 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 28, 2005 on a timely appeal by the Claimant on July 6, 2005.

It should be noted here that the Claimant's benefits were continued 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
_____, RN - Mother
Patrick McKinney, Economic Services 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: Is Mr. _____ required to meet a spenddown before receiving benefits under the SSI-Related Medicaid Program?

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual 10.22 D (11) Spenddown and; West Virginia Income Maintenance Manual 16.9 Medically Needy, Mandatory – For Aged, Blind or Disabled

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Department Summary
D-2 Income Maintenance Policy Manual 16.9 Medically Needy, Mandatory – For Aged, Blind or Disabled
D-3 Scheduling Notice dated 07/06/05
D-4 Request for Hearing dated 06/22/05

Claimants' Exhibits:

C-1 None

VII. FINDINGS OF FACT:

1) 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) West Virginia Income Maintenance Policy Manual 16.9 MEDICALLY NEEDY, MANDATORY - FOR AGED, BLIND OR DISABLED (MS, NS**)**

Income: MNIL **Assets: $2,000**
Possible Spenddown

NOTE: Medically Needy coverage groups are subject to a spenddown provision. The only mandatory Medically Needy coverage group for the aged, blind or disabled is SSI-RELATED MEDICAID.

NOTE: All disabled recipients of SSI-Related Medicaid are mandatory referrals to the Department of Rehabilitative Services (DRS). The penalty for failure to cooperate is removal from the benefit group or case closure, if the client is the only person in the benefit group. The client does not fail to cooperate if he refuses surgery.

Individuals who meet the SSI definition of aged, blind or disabled are eligible for Medicaid when all of the following conditions are met:

- Countable income is under the MNIL.

  The income eligibility requirement is detailed in Chapter 10. However, no SSI-Related case is denied due only to excess income. Instead, incurred medical bills are deducted from countable income for the 6-month Period of Consideration. This process is called spenddown and details of this procedure are in Chapter 10.

  Eligibility and the amount of the spenddown, if any, are determined using the MNIL, not the SSI or cash assistance payment level. The level of the MNIL is determined by each state according to federal guidelines. By law, the MNIL cannot exceed 133% of the State's former AFDC cash assistance payment level, rounded to the nearest $100, for a family of the same size.

  NOTE: Under some circumstances the MNIL for two people is used when determining eligibility for only one person. This is also explained in Chapter 10.

  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 individual 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

- Countable assets do not exceed the limits described in Chapter 11.

NOTE: An aged, blind or disabled person may also be eligible as a member of an AFDC-Related family. The Worker must take the action that will most benefit the client.

3) Mr. Patrick McKinney read the following Hearing Summary:

The client was determined disabled by the Medical Review Team. At the time, he had no income therefore was not required to meet a spenddown. In June 2005, client was determined disabled by the Social Security Administration (SSA). His income was determined to be $963.00 monthly. He was sent notification that he would be required to meet a spenddown. Mr. _____ requested a hearing. The medical card has been reinstated based upon the request.

According to Chapter 16.9, medically needy groups are subject to a spenddown. Mr. _____ meets the eligibility requirements as he has been determined disabled by the Medical Review Team (MRT) and the Social Security Administration (SSA). The amount of the spenddown is determined using the Medically Needy Income Limit (MNIL). The level of the MNIL is determined by each state according to the federal guidelines. Mr. _____ must meet a spenddown amount over $4,000.00

4) Mr. _____ disagrees with the policy requiring a spenddown before he is eligible for SSI-Related Medicaid Benefits. Mr. _____ described himself as a 28 year old male with a severe debilitating condition. He is seeking information in order to appeal the policy as it relates to Medicaid Benefits for disabled individuals.

VIII. CONCLUSIONS OF LAW:

Mr. _____'s income exceeds the Medically Needy Income Limit (MNIL). He must spend his income down to the MNIL by incurring medical expenses to be eligible for the SSI-Related Medicaid Program.

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 October, 2005.

_____

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