STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

Jim Justice
Governor

BOARD OF REVIEW
P.O. Box 1247
Martinsburg, WV 25402

Bill J. Crouch
Cabinet Secretary

Esta es la decision de su Audiencia Imparcial. La decision del Departamento ha sido confirmada/invertido/remitido. Si usted tiene pregunstas, por favor llame a Phillip Owens, 304-267-0100, ext. 71054

September 20, 2017

[redacted]

RE: [redacted] v. WV DHHR, ACTION NO.: 17-BOR-2229

Dear [redacted]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

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.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Lori Woodward, State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: Bureau of Children & Families, WV DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. Action Number: 17-BOR-2229

WEST VIRGINIA DEPARTMENT OF
HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing convened on September 19, 2017, on appeal filed July 31, 2017.

The matter before the Hearing Officer arises from the August 10, 2017, decision by the Respondent to deny the Appellant's Medicaid and/or WV CHIP benefit application.

At the hearing, the Respondent appeared by Ann Hubbard, Economic Service Supervisor. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Hearing Summary
- D-2 Verification request (DFA-6) dated July 31, 2017
- D-3 DFA-6a Medicaid information form
- D-4 Paperwork submitted by the Appellant for spenddown
- D-5 Track Spenddown screen print from Appellant's eRapids case for February 1, 2016 through July 2016
- D-6 WV Income Maintenance Manual §10.22 (excerpt)
- D-7 [redacted] patient account
- D-8 Notice of denial dated August 10, 2017

Appellant's Exhibits:

None

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant applied for Medicaid benefits on July 31, 2017.

2) For the Appellant to qualify for Medicaid, the Respondent determined she must meet a spenddown by providing verification of medical expenses that total $7,392. (Exhibit D-2).

3) On July 31, 2017, notice was sent to the Appellant advising her she must submit verification of eligible medical expenses to meet her spenddown amount by August 10, 2017, or within 30 days from the date of her application. (Exhibits D-2 and D-3)

4) The useable medical expenses submitted by the Appellant totaled $1,266.65. (Exhibits D-1 and D-4)

5) The Respondent allowed for the use of the Appellant's Medicare premium payments for the period of consideration, totaling $654.00. (Exhibit D-1)

6) The Respondent contacted [redacted] to assist in establishing whether there were any useable medical bills. An additional $586.97 was established as an allowable spenddown expense. (Exhibits D-1 and D-7)

7) The Appellant did not have useable medical expenses totaling $7,392 necessary for Medicaid eligibility.

8) The Appellant previously met a spenddown for Medicaid benefits with a period of consideration from February 2016 to July 2016. (Exhibit D-5)

9) A medical expense of $1,645 incurred for her daughter was used to as a medical expense for a previous spenddown in 2016. (Exhibit D-5)

APPLICABLE POLICY

IMM §10.22.D.11, addresses Medicaid spenddown policy:

To receive a Medicaid card, the monthly countable income of the Needs Group must not exceed the amount of the MNIL (Medically Needy Income Limit). 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. An eligibility decision cannot be made until the spenddown is met by providing proof of medical expenses.

The client must provide proof of medical expenses, date incurred, type of expense and amount by the application processing deadline.
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 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.

The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount. If the client does not submit sufficient medical bills by the application processing deadline, the application is denied.

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.

Other allowable medical expenses include health insurance premiums, including Medicare or the enrollment fee for a Medicare-approved discount drug card, Medicaid co-pays, Medicare co-insurance, deductibles and enrollment fees, and necessary medical or remedial care expenses.

DISCUSSION

The Appellant applied for Medicaid for herself and her daughter on July 31, 2017. The Medicaid for her daughter was approved. However, it was determined that the Appellant was potentially eligible for SSI-Related Medicaid for Aged, Blind and Disabled category, which required her to meet a spenddown amount of $7,392. Notice was sent to the Appellant on July 31, 2017 that she may qualify for Medicaid if she can provide medical expenses totaling $7,392. The notice further explained the type of information which was required.

The information submitted by the Appellant included non-billing statements, bills which were used as a medical expense for a previous spenddown, and old statements which did not reflect current information for the Respondent to determine if it could be deemed as a useable medical expense to count towards the spenddown. The Respondent was only able to calculate a total of $1,266.65 of useable medical bills and payments towards the Appellant's spenddown. Additionally, the Respondent calculated six (6) months of paid Medicare premiums, for a total of $654, to be used

for the spenddown. By collateral contact to [redacted] by the Respondent, an additional $586.97 was established as allowable medical expenses. The total useable medical expenses for the Appellant's spenddown equaled $2,507.62. As the Appellant's spenddown amount of $7,392 was not met, the Appellant's Medicaid application was denied. Notice of the denial was sent by the Respondent on August 10, 2017.

The Appellant did not dispute the income used or the spenddown amount which was established. Instead she asserted that the Respondent should have used her Medicare premium deductions from her Social Security Income which was outside of the period of consideration. Additionally, she stated that she submitted a $1,600 medical bill for her daughter which also should have been used. The Appellant's monthly Medicare premium payments were calculated for the six (6) months of the POC. However, Medicare premium payments incurred outside of the POC are not considered as an unpaid balance of an old bill and, thus, is not considered an allowable expense. The $1,600 medical bill for the Appellant's daughter was used in a previous spenddown for the Appellant in 2016.

Because the Appellant did not submit allowable medical bills in the amount of $7,392, the Respondent was correct to deny her Medicaid application.

CONCLUSIONS OF LAW

1. To be eligible for SSI-Related Medicaid for Aged, Blind and Disabled category, which the Appellant was potentially eligible, the Appellant needed to meet a spenddown amount of $7,392.

2. Only $2,507.62 could be established as allowable medical expenses towards the Appellant's spenddown.

3. Because the Appellant did not meet the spenddown amount required for Medicaid eligibility, the Respondent was correct to deny the Appellant's Medicaid application.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Respondent's denial of Medicaid benefits.

ENTERED this 20th day of September 2017.

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Lori Woodward, State Hearing Officer