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

November 2, 2017

[redacted]

RE: [redacted] v. WV DHHR, ACTION NO.: 17-BOR-2428

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: Peter VanKleeck, BCF, [redacted] Co. DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. Action Number: 17-BOR-2428

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 October 31, 2017, on appeal filed September 5, 2017.

The matter before the Hearing Officer arises from the August 18, 2017, decision by the Respondent to close the Appellant's Spenddown Coverage Medicaid.

At the hearing, the Respondent appeared by Peter VanKleeck, Economic Service Supervisor. The Appellant appeared on her own behalf with the help of her granddaughter, [redacted]. All witnesses were sworn, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Hearing Summary
- D-2 Notice of Approval of Spenddown Coverage Medicaid, dated June 28, 2017
- D-3 Notice of Spenddown Coverage Medicaid expiration (CMC4), dated August 18, 2017
- D-4 WV Income Maintenance Manual §10.22 (excerpt)

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 for herself and her husband on June 6, 2017.

2) Due to the Appellant and her husband's income, they needed to meet a spenddown amount before they became eligible for Medicaid.

3) On March 27, 2017, the Appellant and her husband became eligible for Spenddown Coverage Medicaid. (Exhibit D-2)

4) Spenddown Coverage Medicaid is time-limited to a period of six (6) months from the month of established eligibility.

5) The Appellant's Spenddown Coverage Medicaid eligibility was determined to be from March 27, 2017 to August 31, 2017. (Exhibits D-2 and D-3).

6) On August 18, 2017, notice was sent to the Appellant advising her that her Spenddown Coverage Medicaid was expiring on August 31, 2017. (Exhibit D-3)

7) The Appellant incurred medical bills on and after March 27, 2017, which have not been paid by Medicaid.

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 Assistance Group (AG) member(s) may be used to meet the spenddown amount, 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.

IMM 1.22.N.2 explains that spenddown AG's are not re-determined and are closed at the end of the 6th month of the POC. The client must reapply for a new POC.

DISCUSSION

The Appellant applied for Medicaid for herself and her husband on June 6, 2017. Due to their income, the Appellant and her husband had to meet a spenddown amount before they became eligible for Medicaid benefits. Because the Appellant had several medical bills, she and her husband became eligible as of March 27, 2017 for Spenddown Coverage Medicaid. Notice of approval was sent to the Appellant on June 28, 2017. As Spenddown Coverage Medicaid is a six (6) month time-limited benefit, the Appellant and her husband's Spenddown Coverage Medicaid was due to expire on August 31, 2017. The Respondent sent notice of closure on August 18, 2017.

Because the Appellant had medical bills which she incurred from March 27, 2017 which were not yet paid by Medicaid, she filed for a fair hearing requesting that her Medicaid coverage continue until her bills were paid. Per policy, Spenddown Coverage Medicaid can only be established for a six (6) month period, which expired on August 31, 2017. In order to re-establish Spenddown Coverage Medicaid, a new application and spenddown amount must be met. The Board of Review has no authority to extend the Appellant's Spenddown Coverage Medicaid past the time limit established by policy. Issues regarding unpaid bills were not addressed at this hearing as these issues are within the purview of the Bureau of Medical Services (BMS) and should be addressed with BMS. It is noted that after the Appellant has exhausted the established BMS procedures for resolution of these billing issues, then she may have recourse in requesting a fair hearing at that time.

CONCLUSIONS OF LAW

1. The Spenddown Coverage Medicaid is a time-limited program of six (6) months.

2. The Appellant established Spenddown Coverage Medicaid eligibility on March 27, 2017, and thus was covered from March through August 2017.

3. Because the time limit for eligibility had expired, the Respondent was correct to close the Appellant's Spenddown Coverage Medicaid at the end of August 2017.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Respondent's closure of Spenddown Coverage Medicaid.

ENTERED this 2nd day of November 2017.

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Lori Woodward, State Hearing Officer