June 25, 2024

[redacted]

RE: [redacted] v. DoHS/BFA
ACTION NO.: 24-BOR-2221

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 Human Services. These same laws and regulations are used in all cases to ensure 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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Benedict Sokol, [redacted] DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2221**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE,

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 Office of Inspector General Common Chapters Manual. This fair hearing was convened on June 18, 2024, on an appeal filed on May 15, 2024.

The matter before the Hearing Officer arises from the April 1, 2024, decision by the Respondent to deny the Appellant's application for SSI-Related Medicaid.

At the hearing, the Respondent appeared by Benedict Sokol, [redacted] DoHS. The Appellant represented himself. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Board of Review Scheduling Order dated May 21, 2024
D-2 Hearing Request received May 15, 2024
D-3 Notice of Denial dated April 1, 2024
D-4 West Virginia Income Maintenance Manual §4.14.4.J.3
D-5 West Virginia Income Maintenance Manual §4.14.4.J.2
D-6 Case Comments from October 2023 through May 2024
D-7 Correspondence from Humana (undated)
D-8 Charge Summary from [redacted] Hospital

Appellant's Exhibits:

A-1 Correspondence from Humana dated September 28, 2023
A-2 Correspondence from [redacted] dated March 19, 2024

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 November 8, 2023.

2) The Appellant provided a statement of charges incurred at [redacted] Hospital and a letter from Humana with the Medicaid application (Exhibits D-6, D-7, and D-8).

3) The Respondent processed the Appellant's Medicaid application on November 25, 2023 (Exhibit D-6).

4) The Appellant was approved for SSI-Related Medicaid benefits with a spenddown of $7,032.

5) The Respondent's caseworker entered a comment into the Appellant's case record stating "He has sent in some unpaid medical bills. Since he has Medicare, I will call ([redacted] Hospital) to see how much that he still owes" (Exhibit D-6).

6) The Appellant contacted the Respondent several times to inquire about his pending Medicaid application (Exhibit D-6).

7) On April 1, 2024, the Respondent sent a notice of denial to the Appellant advising that his application had been denied because he failed to meet his spenddown within 30 days from the date of application (Exhibit D-3).

APPLICABLE POLICY

West Virginia Income Maintenance Manual Chapter 1 explains the Medicaid application process:

> **1.6.6 Agency Delays**
> When the Department fails to request necessary verification, the Worker must immediately send the eligibility system verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received, and the client is determined eligible, medical coverage is retroactive to the date eligibility would have been established. When the application is not processed within agency time limits, the application must be processed immediately

upon discovery of the delay and coverage must be backdated for any prior eligibility period. This may be more than three months if due to an agency error. If the Department simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the Department acted in a timely manner.

1.6.6.A.1 Instructions for Documenting Pending Medicaid Applications
For all Medicaid applications, the documentation in the eligibility system must include, but is not limited to, the following:

- Date of application.
- Date the verification checklist or DFA-6 and 6A were mailed or given to the client.
- Date medical bills submitted by the client were received in the local office.
- Date medical expenses were added to the eligibility system.
- The result of each 30-day review found on comments (instructions in item 2 below).
- All actions related to the MRT process.

1.6.6.A.2 Procedure for Review of Pending Applications
Applications that have not been entered in the eligibility system must be reviewed at least every 30 days. The county office must establish procedures to ensure that each pending application is reviewed a minimum of once every 30 days. The results of the review must be documented in the case record. Comments must document the reason the application has not been acted on.

- If this reason is not beyond the control of the Department, the Worker must immediately take any actions necessary to process the application.
- If the application has not been acted on within the required time limit due to missing information from the applicant, the Worker must send a DFA-20 or eligibility system notice NMRL to the applicant informing him of the information which has not been received by the Department. The DFA-20 or NMRL is sent to the applicant at the time of the expiration of the maximum allowable time for acting on the application.

1.18.4 Due Date of Additional Information
Additional information related to medical bills is due 30 days from the date of application.

1.18.4 Application Processing Limits
SSI Disability-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 90 days of the date of application.

West Virginia Income Maintenance Manual Chapter 4 explains the spenddown process:

4.14.4.J Spenddown
To be eligible for Medicaid, the Income Group's (IG) monthly countable income must not exceed the amount of the medically needy income limit (MNIL). If the income exceeds the MNIL, the assistance group (AG) has an opportunity to spend the income

down to the MNIL by incurring medical expenses. These expenses are subtracted from the income for the six-month period of consideration (POC), until the income is at, or below, the MNIL for the Needs Group (NG) size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid.

4.14.4.J.1 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. The Worker must also explain the spenddown process to the client. **A DFA-6A is attached to the verification checklist (DFA-6) that notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses.** The DFA-6 must also contain any other information the client must supply in order to determine eligibility. The following procedures are required for the spenddown process.

- The Worker prepares the DFA-6, attaches a DFA-6A and gives them to the client or mails them. **The DFA-6A notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses.** The DFA-6 must also contain any other information the client must supply in order to determine eligibility. 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.
- Medical bills are entered and tracked in the eligibility system as they are received. When the bills or verification are received, the Worker reviews the information to determine:
    - The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.
    - The individual(s) who received the medical service is one of the persons described in Section 4.14.4.J.2 below.
    - The expenses are for medical services and are appropriate to use to meet a spenddown. See Section 4.14.4.J.3 below.
- The Worker must enter the pertinent information about expenses received from the client in the eligibility system. This information includes:
    - The date of service
    - The provider of the service
    - The total amount of the bill
    - The third-party liability amount
- If the client does not submit sufficient medical bills by the application processing deadline, the application is denied. The application is denied when the applicant indicates there are no medical bills or anticipated medical expenses in the 30-day application period that may be used to meet the spenddown for the Medicaid AG member(s).

4.14.4.J.3 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 period of consideration (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 that 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, are 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.

Code of Federal Regulations – 42 CFR §435.121 explains Medicaid coverage for aged, blind and disabled individuals:

> (e)(4) In a State that does not have a medically needy program that covers aged, blind, and disabled individuals, the agency must allow individuals to deduct from income incurred medical and remedial expenses (that is, spend down) to become eligible under this section. However, individuals with income above the categorically needy standards may only spend down to the standard selected by the State under paragraph (e)(2) of this section which applies to the individual's living arrangement.

DISCUSSION

Pursuant to policy, if a Medicaid applicant's countable income exceeds the Medically Needy Income Limit, incurred medical expenses are used to spenddown the income to become eligible. The applicant has thirty (30) days from the date of application to provide medical bills that meet the spenddown amount. The Appellant's application for SSI-Related Medicaid was denied due to his failure to meet his spenddown amount of $7,032 within the allowable time frame.

The Appellant testified that he provided a hospital bill for services incurred in the emergency room on September 4, 2023, for over $10,000 to the Respondent with his Medicaid application on November 8, 2023 (Exhibit D-6). The Appellant stated his Medicare coverage had lapsed in 2023, and it was not reinstated until January 1, 2024. The Appellant provided a letter from Humana, the contracted provider for Medicare, showing that his claim had been denied (Exhibit A-1). The Appellant contended that the denial letter from Humana was also submitted with his November 8 Medicaid application.

The Appellant stated that his hospital bill was turned over to a collection agency in March 2024, and he was advised by the Respondent that once the bill was in collections, it could no longer be used to meet a spenddown (Exhibit A-2). The Appellant argued that the hospital bill was not in collection status when he applied in November 2023, and had the Respondent processed his application timely, the bill could have been used to meet his spenddown.

Policy states that a verification checklist (forms DFA-6 and DFA-6A) is issued when additional information is needed to determine eligibility. The Respondent's caseworker who processed the Appellant's Medicaid application noted in the case record that information was needed from the hospital to determine if any of the hospital bill would be paid by Medicare. No additional comments were made in the case record documenting any attempts to contact the hospital. Furthermore, there was no documentation presented that a verification checklist was sent to the Appellant to allow him the opportunity to provide information needed to determine eligibility.

The Respondent submitted as evidence a copy of the hospital bill and a letter from Humana that was provided by the Appellant with the November 8, 2023, Medicaid application (Exhibit D-7). The letter from Humana that was scanned into the Appellant's case record was incomplete and was only a cover letter of the Humana denial of the September 4, 2023, hospital visit. Credible testimony from the Appellant indicated that the Appellant provided the Humana denial letter to the Respondent with the Medicaid application and only a portion of the full letter was scanned into his case record.

Policy stipulates that a current payment on, or the unpaid balance of an old bill, incurred outside the current period of consideration can be used to meet a spenddown. 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 not an allowable spenddown expense. The Appellant provided a letter from [redacted] a debt collector, explaining that the company is trying to collect a debt owed to [redacted] Hospital incurred on September 4, 2023. Based upon the evidence provided, the debt is still owed to the hospital and is an allowable expense to be used to meet a spenddown.

Whereas the Appellant provided a hospital bill that exceeded his spenddown of $7,032 and verification that the hospital bill would not be paid by Medicare within 30 days of the date of the Medicaid application, the Respondent's decision to deny SSI-Related Medicaid benefits for failure to meet a spenddown cannot be affirmed.

CONCLUSIONS OF LAW

1) If the income exceeds the allowable limit to receive SSI-Related Medicaid, unpaid medical expenses are used to spenddown the income.

2) The applicant has 30 days from the date of application to provide medical bills to meet a spenddown.

3) The Appellant provided a hospital bill exceeding the amount of his spenddown and a denial letter from Humana showing his responsibility for the hospital bill with the November 8, 2023, Medicaid application.

4) The Respondent incorrectly denied the Appellant's application for Medicaid failure to meet a spenddown.

DECISION

It is the decision of the State Hearing Officer to **reverse** the decision of the Respondent to deny the Appellant's application for SSI-Related Medicaid benefits for failure to meet a spenddown. The matter is **remanded** to the Respondent for a determination of a new six-month period of consideration.

ENTERED this 25th day of June 2024.

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Kristi Logan
Certified State Hearing Officer