December 17, 2024

[redacted]

RE: [redacted] A PROTECTED INDIVIDUAL v. WVDoHS/BFA
ACTION NO.: 24-BOR-3652

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 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, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Amanda Stowers, WVDoHS/BFA

BEFORE THE WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted] A PROTECTED INDIVIDUAL,

Appellant,

v. **Action Number: 24-BOR-3652**

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] A PROTECTED INDIVIDUAL. 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 December 11, 2024.

The matter before the Hearing Officer arises from the Respondent's October 30, 2024 determination of the Appellant's contribution amount for her Long Term Care (LTC) Medicaid.

At the hearing, the Respondent appeared by Amanda Stowers, Bureau for Family Assistance. The Appellant was represented by her son and attorney-in-fact, [redacted] The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 West Virgina Income Maintenance Manual (WV IMM), Chapter 24, §§24.7.2.C, 24.7.2.D, 24.7.2.D.1, 24.7.3, 24.7.3.A, 24.7.3.A.1, 24.7.3.A.2, 24.7.3.A.3, 24.7.3.A.4, 24.7.3.A.5 (excerpt)
- D-2 [redacted] rights distribution statement
- D-3 2023 IRS Form 1099-R
- D-4 2023 SSA Benefit Amount Statement
- D-5 [redacted] checking account, as of October 11, 2024
- D-6 Screen print case comments dated October 7, 8, 18, 2024
- D-7 Screen print Long Term Care Budget calculations

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 was admitted to [redacted] on May 23, 2024. (Exhibit D-6)

2) A Long Term Care (LTC) Medicaid application was made on behalf of the Appellant on September 6, 2024. (Exhibit D-6)

3) On September 9, 2024, a Pre-Admission Screening (PAS) form was completed and it was determined that the Appellant was not expected to return home. (Exhibit D-6)

4) The Respondent calculated the Appellant's monthly gross income to be $2,789.29 from monthly mineral rights distribution, pension, and social security income. (Exhibits D-2 through D-5)

5) The Respondent subtracted the Personal Need Allowance of $50, Medicare Premium expense of $174.70, and health insurance premium of $56, for a total resource amount of $2,508.59.

6) The Appellant's representative contended the Appellant's tax obligation should have been deducted from her gross income in calculating her resource amount.

APPLICABLE POLICY

Code of Federal Regulations, 42 CFR §735.25, in part:

(a) ***Basic rules.***

(1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) ***Applicability.*** This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under §435.110 or §435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under §435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under §435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) ***Required deductions.*** In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) ***Personal needs allowance.*** A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) ***Maintenance needs of spouse.*** For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under §435.230; or

(iii) The amount of the medically needy income standard for one person established under §435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) ***Maintenance needs of family.*** For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under §435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) ***Expenses not subject to third party payment.*** Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) ***Continued SSI and SSP benefits.*** The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) ***Optional deduction: Allowance for home maintenance.*** For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—
(1) The amount is deducted for not more than a 6-month period; and
(2) A physician has certified that either of the individuals is likely to return to the home within that period.
(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—
(i) The amount is deducted for not more than a 6-month period; and
(ii) A physician has certified that either of the individuals is likely to return to the home within that period.
(e) ***Determination of income*** —
(1) ***Option.*** In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.
(2) ***Basis for projection.*** The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.
(3) ***Adjustments.*** At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.
(f) ***Determination of medical expenses*** —
(1) ***Option.*** In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.
(2) ***Basis for projection.*** The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.
(3) ***Adjustments.*** At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

WV IMM, Chapter 24, §24.7.2.C, *Nursing Facility Coverage Group, Gross Income Test*:
If the client is not currently eligible by having QMB or full coverage Medicaid, Medicaid eligibility may be established as follows:

- If the client's gross countable monthly income is equal to or less than 300% of the current maximum Supplemental Security Income (SSI) payment for one person and the client is institutionalized, he may be eligible.
- SSI-Related Categorical Medicaid requirements (aged, blind or disabled) and asset guidelines must be met. These clients' contribution toward cost of care is determined in the post-eligibility process. There is no spenddown amount for these clients.

WV IMM, Chapter 24, §24.7.3, *Post-Eligibility Process:*
The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19, or certain QMB clients. MAGI Medicaid coverage groups and QMB clients for whom Medicare pays a full month do not contribute to the cost of their nursing facility care. Income sources that are excluded for the

coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 4.3 for excluded sources for the appropriate coverage group. 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 spenddown amount, if any, as determined above, is added to the resource 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 spenddown is not added to the computed resource amount. The spenddown is used only to compare to the nursing facility's Medicaid cost of care to determine eligibility. See Section 24.7.6

WV IMM, Chapter 24, §24.7.3.A, *Income Disregards and Deductions*:
Only the items in the following sections may be deducted from the client's gross income in the post-eligibility process.

WV IMM, Chapter 24, §24.7.3.A.1, *Client's Personal Needs Allowance (PNA)*:
This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. For most residents, the monthly amount deducted is $50. However, for an individual who is receiving the reduced Veterans Affairs (VA) pension of $90, the monthly PNA is $90. Similarly, an individual receiving SSI will have his monthly allocation reduced to $30, which is his monthly PNA if he is in the facility for at least three months.

WV IMM, Chapter 24, §24.7.3.A.5, *Non-Reimbursable Medical Expenses (NRME),* in part:
Certain non-reimbursable medical expenses for the eligible client only may be deducted in the post-eligibility process. These expenses are sometimes referred to as "remedial expenses." 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.

These allowable expenses are listed in Section 4.14.4.J.3. 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.

➢ Deductible Premiums
Deductible premiums include any portion of the Medicare Part D Premium that is not covered by the Low Income Subsidy (LIS). The incurred expense must be the responsibility of the client. The total deduction for medical insurance premiums is given to the person who pays the premium, regardless of which individual carries the insurance coverage. The deduction is not split between the spouses, even if both are receiving nursing facility services. See Chapter 7 for sources of insurance premium verification.

➢ Time Limits and Verification Requirements for Expenses

- Applicants

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the three months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources and nursing facility expenses incurred during the three months prior period when the client was ineligible for Medicaid due to excessive assets. Only a current payment on, or the unpaid balance of, old bills incurred outside the period of consideration may be permitted as an NRME. See Section 4.14.4.J.3.
EXCEPTION: A deduction may be given if there is evidence of a payment in the three months prior to application, even when the expense was incurred prior to that time.

- **Clients Residing in a Nursing Facility**

The request for consideration of a non-reimbursable medical expense must be submitted within one 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. 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.

WV IMM, Chapter 24, §24.7.6, *Determining the Client's Total Contribution*:
If the individual is a full Medicaid coverage client or in the Nursing Facility Medicaid coverage group without a spenddown, the resource amount determined in the post eligibility process from above is his total cost contribution. Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care, unless the client has a community spouse. This amount is added to the resource amount determined above to determine the client's total monthly contribution toward the cost of his nursing care.

WV IMM, Chapter 4, Appendix A, in part: 300% of the maximum SSI payment is $2,829

DISCUSSION

State and federal regulations require that a LTC applicant's contribution toward the cost of nursing facility care be determined by applying the allowable income deductions to the gross countable income. The remainder, after all allowable deductions, is the resource amount, which is the amount the client must contribute toward the cost of care.

The Appellant's representative, [redacted] did not contest the amount of the gross income; instead, he contended that the net amount of the Appellant's income should be used. [redacted] stated that the Appellant only receives a total of $2,218 per month and that the gross amount is not available. [redacted] testified that the Appellant is responsible for taxes on the gas wells that must be paid and believes that should be deducted from the gross amount.

Additionally, [redacted] testified that the asset total was not reflective of a prescription expense and co-pay of $100 that had to be paid from her bank account in September 2024. The Appellant's assets were not at issue in the Respondent's determination of her contribution towards her cost of care.

Policy requires that the total gross income must be used before applying any allowable deductions. Tax obligations are not considered an allowable deduction from gross income, per policy. The Respondent's representative, Amanda Stowers, testified that the allowable deductions made to the calculations were for the Appellant's Medicare premium of $174.70, health insurance premium of $56, and a personal needs allowance of $50. No other allowable deductions were attributable by policy.

Although [redacted] position is understandable, the Board of Review cannot make exceptions to policy and can only determine if the Respondent followed the policy when deciding the Appellant's Medicaid LTC benefit eligibility. The preponderance of evidence revealed that the Respondent correctly used the Appellant's gross income in calculating the amount of her contribution towards her cost of care as required by policy.

CONCLUSIONS OF LAW

1) A client's contribution toward the cost of nursing facility care is determined by applying the allowable income deductions to the gross income. The remainder, after all allowable deductions, is the resource amount, which is the amount the client must contribute toward his cost of care.

2) The Respondent applied the personal needs allowance deduction, a non-reimbursable medical expense deduction, and the Medicare premium when determining the Appellant's monthly contribution.

3) No other deductions to gross income allowable by policy were established at the hearing.

DECISION

It is the decision of the Hearing Officer to **UPHOLD** the Respondent's determination of the Appellant's resource amount for her LTC Medicaid.

ENTERED this 17th day of December 2024.

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Lori Woodward**,** Certified State Hearing Officer