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

Bill J. Crouch
Cabinet Secretary

Board of Review
416 Adams Street Suite 307
Fairmont, WV 26554
304-368-4420 ext. 79326

M. Katherine Lawson
Inspector General

February 13, 2018

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 18-BOR-1012

Dear Ms. [redacted]:

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

In arriving at a decision, the Board of Review 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 that may be taken if you disagree with the decision reached in this matter.

Sincerely,

Tara B. Thompson
State Hearing Officer
State Board of Review

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

cc: Amanda Seese, [redacted] County DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted]

Appellant,

v. **ACTION NO.: 18-BOR-1012**

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 was convened on January 31, 2018, on an appeal filed December 28, 2017.

The matter before the Hearing Officer arises from the December 19, 2017 decision by the Respondent to terminate Adult Medicaid benefits due to income exceeding the Medicaid benefit eligibility limit.

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

EXHIBITS

Department's Exhibits:

D-1 Notice of Adult Medicaid termination, dated December 19, 2017
D-2 [redacted] Paystubs, dated December 1, 2017 and December 15, 2017
D-3 West Virginia Income Maintenance Manual (WVIMM) Policy §1.6.11. A.2 through §1.9.6. B; WVIMM §4 Appendix A

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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) The Adult Group is a categorically mandatory Medicaid coverage group established by the Affordable Care Act (ACA).

2) The Appellant received Adult Medicaid benefits for a one-person Assistance Group (AG). (Exhibit D-1)

3) In December 2017, the Appellant applied for Supplemental Nutrition Assistance Program (SNAP) benefits to be added to her case.

4) The Appellant submitted two paystubs verifying income for her SNAP application. (Exhibit D-2)

5) The Appellant had bi-weekly income of $1,227.52. (Exhibit D-2)

6) The Appellant's gross monthly income totaled $2,639.17. (Exhibit D-1)

7) The Respondent correctly calculated the Appellant's gross monthly income.

8) The Adult Medicaid monthly income eligibility limit for a one-person AG is $1,337. (Exhibit D-3)

9) The Appellant's gross monthly income was over the Medicaid benefit income eligibility limit for a one-person AG. (Exhibits D-2 and D-3)

10) On December 19, 2017, the Respondent issued a notice advising the Appellant that her Adult Medicaid benefits would stop after December 31, 2017. (Exhibit D-1)

11) The Respondent's December 19, 2017 notice of adverse action was timely. (Exhibit D-1)

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) §1.2.2.C Case Maintenance provides in part:

> A review may be conducted at any time on a single or combination of questionable eligibility factor(s). The case maintenance process may involve a review or activities that update the Department's information about the client's circumstances between the application and the first redetermination and between redeterminations. Changes in eligibility or the benefit amount may occur. If so, eligibility system action and client notification of any changes are required.

WVIMM §3.7 Adult Group provides in part:

> The Affordable Care Act (ACA) established the categorically mandatory coverage group known as the Adult Group, effective January 1, 2014…

WVIMM §23.10.4 Adult Group Income Guidelines provides in part:

> Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7

Medicaid coverage in the Adult Group is provided to individuals who meet the following requirements:

- They are age 19 or older and under age 65;
- They are not eligible for another categorically mandatory Medicaid coverage group: SSI, Deemed SSI, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19, Former Foster Children;
- They are not entitled to or enrolled in Medicare Part A or B; and
- The income eligibility requirements described in Chapter 4 are met. [Emphasis Added]

To be financially eligible for Adult Medicaid, income must be at or equal to 133% of the Federal Poverty Level.

WVIMM §4 Appendix A- Income Limits provides in part:

For a one-person household, the income limit at 133% of the Federal Poverty Level equals $1,337.

WVIMM §4.6.1. D How to Use Past and Future Income provides in part:

After the worker determines all of the income sources that are to be considered for use, the worker determines the amount of monthly income based on the frequency of receipt and whether the amount is stable or fluctuates…

When income is stable and received more often than monthly, convert the amount per period to a monthly amount by finding the average amount per period and converting to monthly amount:

Bi-weekly amount (every two weeks) x 2.15 = amount of monthly income

WVIMM §9.3.1 Advanced Notice Requirements provides in part:

A client must receive advanced notice for Medicaid matters when the adverse action is an AG closure or removal of a client from the AG. The advanced notice requirement is that notification be mailed to the client at least 13 days prior to the first day of the month in which the benefits are affected.

DISCUSSION

The Appellant was a recipient of Adult Medicaid benefits. She applied for Supplemental Nutrition Assistance Program (SNAP) benefits to be added to her case. During review of the Appellant's benefit eligibility, the Respondent determined that the Appellant's gross monthly income exceeded income eligibility guidelines for Adult Medicaid benefits. On December 19, 2017, the Respondent issued a notice advising the Appellant that her Adult Medicaid benefits would stop due to income exceeding the Medicaid benefit eligibility limit. The Appellant contended that the Respondent's notice of adverse action should have been issued thirty (30) days prior to the termination of her Medicaid benefits. The Appellant contested the Respondent's decision and argued that she was eligible for Adult Medicaid without consideration of income or assets pursuant to the Affordable Care Act.

The Respondent bears the burden of proof. To demonstrate that it acted according to policy, the Respondent had to prove by a preponderance of evidence that the Appellant's income exceeded Adult Medicaid eligibility guidelines. Additionally, the Respondent had to demonstrate that the December 19, 2017 notice was issued timely.

When the Respondent received income verification that conflicted with the Appellant's case record, the worker had the responsibility to update the Appellant's case record and redetermine the Appellant's Medicaid benefit eligibility. To determine the Appellant's eligibility for Adult Medicaid, the Respondent had to determine the Appellant's gross monthly income amount. The Respondent determined gross monthly income by finding the average bi-weekly income amount and converting it to a monthly amount as outlined in policy.

Appellant's bi-weekly income:	$1,227.52	
	x 2.15	
	$2,639.17	Appellant's gross monthly income amount

The Adult Group is a categorically mandatory Medicaid coverage group established by the Affordable Care Act (ACA). Eligibility for participation in the Adult Group is determined by using Modified Adjusted Gross Income (MAGI) methodologies. The Appellant's assertion that her income and assets should not be considered for Medicaid eligibility pursuant to the ACA was incorrect. For a one-person Assistance Group (AG), the Appellant's gross monthly income could not exceed $1,337 to be eligible for Adult Medicaid benefits. The Respondent correctly converted the Appellant's bi-weekly income into a gross monthly income amount. The Appellant's gross monthly income of $2,639.17 exceeded the Adult Medicaid income eligibility limit for a one-person AG.

Policy requires that the Respondent issue a notice of Medicaid closure to the Appellant at least thirteen (13) days prior to the first day of the month in which benefits are affected. The Respondent's December 19, 2017 closure notice advised the Appellant that her Adult Medicaid benefits would be terminated effective January 1, 2018. The Appellant was appropriately notified that her Adult Medicaid benefits would stop thirteen (13) days prior to the first day of the month in which she would cease to have Medicaid coverage.

The Respondent proved by a preponderance of evidence that the Appellant's income exceeded the Adult Medicaid eligibility guidelines for a one-person AG. The Respondent met its burden of proof to demonstrate that it timely issued a notice advising the Appellant that her Adult Medicaid benefits would stop.

CONCLUSIONS OF LAW

1) The Adult Group is a categorically mandatory Medicaid coverage group established by the Affordable Care Act (ACA) that determines applicant eligibility by using Modified Adjusted Gross Income (MAGI) methodologies.

2) The Adult Medicaid income eligibility limit for a one-person Assistance Group (AG) is $1,337.

3) The Appellant's gross monthly income totaled $2,639.17 and exceeded the Adult Medicaid income eligibility limit for a one-person AG.

4) The Respondent was correct in terminating the Appellant's Adult Medicaid benefits due to her income exceeding the Medicaid benefit income eligibility limit.

5) The Respondent was required to issue a thirteen (13) day advanced notice advising the Appellant that her Medicaid benefits would stop.
6) The Respondent's December 19, 2017 notice of Adult Medicaid termination was issued timely to the Appellant.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Department's decision to terminate the Appellant's Adult Medicaid benefits due to her income exceeding the Medicaid benefit income eligibility limit.

ENTERED this 13th day of February 2018.

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Tara B. Thompson
State Hearing Officer