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

Jolynn Marra
Interim Inspector General

November 20, 2019

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 19-BOR-2434

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
Form IG-BR-29

cc: Makiba Hopkins, [redacted] County DHHR
Justin Thorne, [redacted] County DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **ACTION NO.: 19-BOR-2434**

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' (DHHR) Common Chapters Manual. This fair hearing was convened on November 7, 2019 an appeal filed September 24, 2019.

The matter before the Hearing Officer arises from the September 12, 2019 determination by the Respondent to terminate the appellant's Adult Medicaid benefits.

At the hearing, the Respondent appeared by Makiba Hopkins, [redacted] County DHHR. The Appellant appeared *pro se*. Both witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:
D-1 West Virginia Income Maintenance Manual (WVIMM) Chapter 4, Income Chart and §§ 4.7.3.A- 4.7.5.A.1
D-2 Case Comments, dated September 11, 2019 through September 24, 2019
D-3 WVIMM § 4.3.2
D-4 eRAPIDS Unearned Income print-out
D-5 eRAPIDS MAGI Medicaid Income Budget print-out
D-6 DHHR Notice, dated September 25, 2019

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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) The Appellant was a recipient of Adult Medicaid benefits.

2) On September 12, 2019, the Respondent issued a notice advising the Appellant that her Adult Medicaid benefits would be terminated, effective October 1, 2019, due to her income exceeding the Medicaid income eligibility limit.

3) The Appellant is the only member of her Assistance Group (AG) (Exhibit D-2).

4) The Appellant is an adult older than age 19 and under age 65.

5) On September 5, 2019, the Appellant reported unearned income (Exhibit D-2).

6) On September 5, 2019, the Respondent documented in case comments that the Appellant "is disabled through SSA," and "the disability date that was verified by SOLQ as November 1, 2012" (Exhibit D-2).

7) The Respondent's case comments reflected that the Appellant was receiving "disability/wage earner SS benefits" (Exhibit D-2).

8) The Appellant's gross monthly unearned income amount is $1,667, or 160% of the Federal Poverty Level (FPL).

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 23.10.4 Adult Group provides in part:

> The Medicaid Adult Group was created pursuant to the Affordable Care Act (ACA). Eligibility is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.
>
> To be eligible for Medicaid Adult Group coverage, the individual must:
> - Be age 19 or older and under age 65
> - Not be eligible for another categorically mandatory Medicaid coverage group such as SSI, Deemed SSI, Parent/Caretaker Relatives, Pregnant Women, Children Under Age 19, and Former Foster Children.
> - Not be enrolled in Medicare Part A or B; and
> - Be income eligible pursuant to Chapter 4

- Be income must be at or below 133% of the Federal Poverty Level

WVIMM §§ 4.7.2- 4.7.2.B Calculating the MAGI provides in part:

MAGI-based income includes:
Adjusted gross income (taxable income less deductions/adjustments)
Non-taxable Social Security benefits
Tax-exempt interest
Foreign earned income

The Worker must add all of the individual's countable income and exclude income that is not countable pursuant to Section 3.4, Chart 2. Then, the Worker must apply any adjustments or deductions. Eligible adjustments/deductions can be found on page one of IRS form 1040.

WVIMM § 4.7.3 MAGI-Based Income Disregards provides in part:

The only allowable income disregard is an amount equivalent to five percentage points of 100% of the Federal Poverty Level (FPL) for the applicable MAGI household size.

The 5% FPL disregard is not applied to every MAGI eligibility determination. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

WVIMM § 4.7.4 Determining MAGI Eligibility provides in part:

Step 1:	Determine the MAGI-based gross monthly income
Step 2:	Convert the MAGI gross monthly income to a percentage of the FPL by dividing the current monthly income by 100% of the FPL for the household size. Convert the result to a percentage…
Step 3:	If the result from Step 2 is greater than the appropriate limit, apply the 5% FPL disregard by subtracting five percentage points from the converted monthly gross income to determine the household income.
Step 4:	After the 5% FPL income disregard has been applied, the remaining percent of FPL is the final figure that will be compared against the applicable modified adjusted gross income standard for the MAGI coverage groups.

WVIMM Chapter 4, Appendix A:

100% of the Federal Poverty Level (FPL) for a one-person Assistance Group (AG) is $1,041.

133% of the FPL for a one-person AG is $1,385

WVIMM §§ 10.6.5.A-B Assistance Group (AG) Closures and § 10.8.1 Change in Income provides in part:

> When the client's income changes to the point that she becomes ineligible, the AG is closed. The Department is required to consider the individual's Medicaid eligibility under other coverage groups prior to notifying the individual that Medicaid eligibility will end. Advanced notice is required for any adverse action.

WVIMM § 23.8.1 Consideration of All Medicaid Coverage Groups provides in part:

> The client cannot be expected to know which Medicaid coverage groups to apply for. When the client expresses interest in applying for Medicaid, the Worker must explore eligibility for all Medicaid coverage groups …. The DHHR must request additional information needed to evaluate the client's potential eligibility for non-MAGI Medicaid when the client requests such a determination and when the DHHR has information indicating such potential eligibility.

WVIMM § 23.9 Relationship Between Coverage Groups provides in part:

> All Medicaid coverage groups are assigned to one of two categories: Categorically Needy and Medically Needy.
>
> *Categorically Needy Medicaid* clients are families and children; aged, blind, or disabled individuals; and pregnant women who are eligible to receive Medicaid because they fall into a certain category AND meet financial criteria.
>
> *Medically Needy Medicaid* clients are those who would be eligible for Categorically Needy benefits except that their income and/or assets are too high. Even though their resources are too high for Categorically Needy Medicaid eligibility, they have high medical needs and cannot afford to pay their medical bills. These individuals are allowed to "spenddown" their excess income to the Medically Needy Income Level (MNIL) by incurring medical expenses. The spenddown process is explained in Chapter 4.

DISCUSSION

The Appellant is an Adult Medicaid benefit recipient. The Appellant testified that she began receiving Social Security retirement income in June 2019. The evidence demonstrated that the Respondent verified the Appellant's report through SOLQ, a data match with the Social Security Administration (SSA). Policy requires the Respondent to redetermine an individual's Adult Medicaid eligibility when a change of income is reported. When the reported change causes the individual to fail to meet Adult Medicaid eligibility guidelines, the Respondent is required to submit advanced notice of closure and evaluate the individual for other Medicaid coverage groups.

On September 12, 2019, the Respondent issued a notice advising the Appellant that her Adult Medicaid benefits would be terminated due to her income exceeding Medicaid eligibility guidelines. The Appellant requested that following the decision of the Board of Review that her Medicaid benefits be extended until the end of the year

The Respondent had to demonstrate by a preponderance of evidence that the Appellant's income exceeded Adult Medicaid income eligibility guidelines and that the Respondent evaluated the Appellant for other types of Medicaid prior to advising her of closure. The Appellant testified that she requested a hearing to determine what other types of Medicaid benefits she might qualify for. The Board of Review cannot advise the Appellant regarding her eligibility for other programs and can only determine if the Respondent took correct action when terminating the Appellant's Adult Medicaid.

Income

The Appellant did not contest the amount of unearned income used to determine her Medicaid benefit eligibility. No evidence was entered to demonstrate that the Respondent had considered any excluded income pursuant to WVIMM Chapter 4, Chart 2. No evidence was entered to demonstrate that the Appellant had reported any qualifying adjustments or deductions pursuant to WVIMM §4.7.2.B. The Respondent testified that due to only receiving unearned income, the Appellant did not receive a 5% income disregard. The Respondent's failure to apply the 5% disregard and reasoning for exclusion are incorrect. Policy does not specify that the 5% income disregard should not be applied pursuant to the type of earned or unearned income. If the Appellant's converted income percentage was higher than the appropriate FPL, policy instructs that the 5% disregard be applied. Even with application of the 5% disregard, the evidence demonstrated that the Appellant's income would exceed the allowable 133% FPL. Because policy requires an individual's MAGI income to be at or below 133% of the FPL and the Appellant's income exceeded this eligibility limit, the Respondent correctly terminated the Appellant's Adult Medicaid benefits.

Other Medicaid Eligibility

During the hearing, the Appellant testified that she is under age 65. The Respondent's evidence indicated that the Appellant was disabled and that her disability ate had been confirmed by SOLQ as of November 1, 2012. The Appellant argued that she is medically needy. The Appellant testified that she had many medical conditions and that her medications cost $30,000 annually. The Appellant testified that she recently had surgery on both her hand and foot. Evidence demonstrated that the Respondent referred the Appellant to the Federally Facilitated Marketplace (FFM), that she had contacted the marketplace, and that the lowest premium she was offered exceeded $1,000 per month –which she could not afford.

Policy requires that the Respondent assess the Appellant's Medicaid eligibility prior to terminating Adult Medicaid benefits. Pursuant to the Respondent's review of additional Medicaid eligibility, evidence demonstrated that the Appellant was not financially eligible for other categorically needy Medicaid groups. Because the Appellant did not meet financial eligibility for other categorically needy Medicaid groups, the Respondent mailed the Appellant information related to Medicaid spenddown eligibility. The Appellant testified that she had received the spenddown material and had not yet submitted the information for consideration of Medicaid spenddown eligibility. The

preponderance of evidence demonstrated that the Respondent met its responsibility to assess the Appellant for eligibility for other Medicaid coverage groups.

CONCLUSIONS OF LAW

1) To be eligible for Adult Medicaid benefits, the Appellant's gross monthly income must be at or below 133% of the Federal Poverty Level (FPL).

2) The Appellant's gross monthly income exceeded 133% of the FPL.

3) The Respondent correctly terminated the Appellant's Adult Medicaid benefits due to her income exceeding Medicaid eligibility guidelines.

4) There are no policy exceptions which allow the Board of Review to extend Medicaid benefits when the Respondent has taken correct termination action.

DECISION

It is the decision of the State Hearing Officer to **Uphold** the Respondent's decision to terminate the Appellant's Adult Medicaid benefits.

ENTERED this 20th day of November 2019.

_____

Tara B. Thompson
State Hearing Officer