STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Inspector General
Board of Review

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Christopher G. Nelson
Interim Inspector General

August 10, 2023

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 23-BOR-1909

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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

Encl: Decision Recourse
Form IG-BR-29
CC: Beverly Hart, [redacted] DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 23-BOR-1909**

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 June 27, 2023.

The matter before the Hearing Officer arises from the Respondent's May 24, 2023 decision to terminate the Appellant's Adult Medicaid benefits after May 31, 2023.

At the hearing, the Respondent was represented by Beverly Hart, [redacted] DHHR. The Appellant appeared and represented himself. All those present were sworn in and the following documents were admitted into evidence.

Department's Exhibits:
None

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 for a one-person Assistance Group (AG).

2) During the coronavirus disease 2019 (COVID-19) public health emergency (PHE), the Appellant remained eligible for Medicaid benefits — without consideration of his income — pursuant to the Families First Coronavirus Response Act (FFCRA) continuous coverage provisions.

3) On May 24, 2023, the Respondent issued a notice advising the Appellant his Adult Medicaid benefits would end after May 31, 2023, because his income exceeded Medicaid income eligibility guidelines.

4) The Respondent's May 24, 2023 notice reflected a monthly income amount of $2,117.24 for the Appellant.

5) On April 11, 2023, the Appellant received $1,131.10 gross earned income for the March 21 through April 3, 2023 pay period.

6) On April 25, 2023, the Appellant received $971.07 gross earned income for the April 4 through April 17, 2023 pay period.

7) On May 9, 2023, the Appellant received $852.12 gross earned income for the April 18 through May 1, 2023 pay period.

8) The Respondent did not apply any income deductions when determining the Appellant's Adult Medicaid eligibility.

APPLICABLE POLICY

Families First Coronavirus Response Act and Fiscal Year (FY) 2023 Omnibus Appropriations Bill provide in relevant sections:

During the COVID-19 PHE, provisions were stipulated permitting the Respondent to provide continuous coverage to Medicaid recipients, regardless of income, during the PHE. On December 23, 2022, Medicaid continuous enrollment was set to end on April 1, 2023.

West Virginia Income Maintenance Manual (WVIMM) § 1.2.2.B *Redetermination Process* provides in relevant sections:

> Periodic reviews of total eligibility for recipients are mandated by federal law.

West Virginia Income Maintenance Manual (WVIMM) § 4.3.2 *Countable Sources of Income* provides in relevant sections:

For determining Modified Adjusted Gross Income (MAGI) Medicaid Adult Group eligibility, bonuses and awards, wages, salaries, and tip income are countable sources of income.

WVIMM § 4.6.1 *Budgeting Method* provides in relevant sections:

Eligibility is determined monthly. Therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the AG. For all cases, income is projected. Past income is used only when it reflects the income the client reasonably expects to receive during the certification period.

WVIMM § 4.6.1.A *Methods for Reasonably Anticipating Income* provides in relevant sections:

Use past income only when both of the following conditions exist for a source of income:

- Income from the source is expected to continue into the certification period.
- The amount of income from the same source is expected to be more or less the same. For these purposes, the same source of earned income means income from the same employer, not just the continued receipt of earned income.

Use future income when either of the following conditions exists for a source of income:

- Income from a new source is expected to be received in the certification period. For these purposes, a new source of earned income means income from a different employer.
- The rate of pay or the number of hours worked for an old source is expected to change during the certification period. Income that normally fluctuates does not require the use of future income.

WVIMM § 4.6.1. *Consideration of Past Income* provides in relevant sections:

> Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days before the redetermination date …When, in the Worker's judgment, future income may be more reasonably anticipated by considering the income from a longer period, the Worker considers income for the time period [the Worker] determines to be reasonable …
>
> Step 2: Determine if the income from the previous 30 days is reasonably expected to continue into the new certification period …If the income is expected to continue, determine if the amount is reasonably expected to be more or less the same …

WVIMM § 4.6.1.D *How to Use Past and Future Income* provides in relevant sections:

The Worker determines the amount of monthly income based on the frequency of receipt and whether the amount is stable or fluctuates.

When the frequency receipt is less often than monthly and the amount fluctuates, prorate to find the amount for the intended period. If monthly, convert or prorate the amount. Conversion of income to a monthly amount is accomplished by multiplying an actual or average amount as follows:

- Weekly amount x 4.3
- Biweekly amount (every two weeks) x 2.15
- Semimonthly (twice/month) x 2

Proration of income to determine a monthly amount is accomplished by dividing the amount received by the number of periods it is intended to cover as follows:

- Bimonthly amount (two months) ÷ 2
- Quarterly amount (three months) ÷ 3
- Semi-annual amount (twice/year) ÷ 6
- Annual amount ÷ 12
- Six-week amount ÷ 6 and converted to the monthly amount by using x 4.3
- Eight-week amount ÷ 8 and converted to the monthly amount by using x 4.3

WVIMM §§ 4.7 and 4.7.2 *MAGI Methodology* provides in relevant sections:

The MAGI methodology is used to determine financial eligibility for the Medicaid Adult Group.

WVIMM § 4.7.2 *Calculating MAGI* provides in relevant sections:

MAGI based income includes adjusted gross income (taxable income less deductions/adjustments) …

To calculate the MAGI, determine the adjusted gross income amount for the current month …. The Worker uses the budgeting method established in Section 4.6.1 to anticipate future income amounts, consider past income sources, and build monthly income amounts based on the applicant's reported income.

WVIMM §§ 4.7.3 *MAGI-Based Income Disregard* and 4.7.3.A *MAGI-Based Income Disregards Examples provides* in relevant sections:

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 and should not be used to determine the MAGI coverage group for which an individual may be eligible. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

Adult Group Example 1: A client has MAGI household income at 137% of the FPL. The 5% FPL disregard would be applied to bring his income below 133% of the FPL for the Adult Group.

WVIMM § 4.7.4 *Determining Eligibility* provides in relevant sections:

The AG's income must be at or below the applicable MAGI standard for the MAGI coverage groups.

Step 1: Determine the MAGI-based gross monthly income …

Step 2: Convert the MAGI household's 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. If the result from Step 2 is equal to or less than the appropriate income limit, no disregard is necessary, and no further steps are required.

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 § 23.10.4 *Adult Group* and Chapter 4, Appendix A *Income Limits* provide in relevant sections:

To be eligible for Adult Group Medicaid benefits, the income must be equal to or below 133% FPL. For a one-person AG, 100% of the FPL is $1,215 and 133% of the FPL is $1,616.

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 he 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 § 23.9 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 Respondent terminated the Appellant's Adult Medicaid benefits because the amount of the Appellant's gross monthly income exceeded the Adult Medicaid eligibility guidelines for a one-person AG. The Appellant contested the Respondent's income calculations and argued Medicaid benefits are necessary to receive treatment for his medical condition.

Pursuant to the COVID-19 PHE-related procedures, the Respondent did not consider the Appellant's income when determining her Medicaid eligibility during the COVID-19 PHE. After April 1, 2023, the Respondent was permitted to resume considering income when determining Medicaid eligibility.

The Board of Review is required to follow the policy and cannot change the policy or award Adult Medicaid eligibility beyond the circumstances provided in the policy. This Hearing Officer is unable to grant the Appellant relief by awarding income exclusions or Adult Medicaid eligibility exceptions beyond the policy provisions. To be eligible for Adult Medicaid, the Appellant's gross monthly income could not exceed $1,616. The Respondent had to prove by a preponderance of the evidence that the Appellant's gross monthly income exceeded $1,616 at the time of the Respondent's decision.

Income Calculations

During the hearing, the Respondent's witness testified that the Appellant's gross monthly income was $2,117.24 and that the monthly amount was calculated considering bi-weekly income. During the hearing, the Appellant argued the Respondent's representative's testimony was inconsistent with the Respondent's previous explanations of the calculations.

The policy requires the Respondent to consider the amount of the Appellant's income received in the previous thirty (30) days and that a longer period of income may be considered to obtain a clear picture of the Appellant's reasonably anticipated income. Pursuant to the policy, the Respondent must convert the Appellant's gross bi-weekly earned income amount into a monthly amount to determine Adult Medicaid eligibility. During the hearing, the Respondent's representative testified the income considered was reflected on the paystubs provided. The Appellant did not refute the bi-weekly income amounts reflected on the three submitted paystubs. The preponderance of the evidence revealed that no income deductions were applied or should have been applied when determining the amount of the Appellant's countable income.

Income Total

$ 1,131.10	gross earned income for March 21 through April 3, 2023
971.07	gross earned income for April 4 through April 17, 2023
+ 852.12	gross earned income for April 18 through May 1, 2023
$ 2,954.29	total gross income for three bi-weekly periods

To get an average bi-weekly amount, divide the total by the number of periods the amount is intended to cover:

Average Bi-Weekly Income

$2,954.28 ÷ 3 = $984.76 average bi-weekly income

Pursuant to the policy, to obtain the gross monthly income amount, the average bi-weekly income amount is multiplied by 2.15:

Bi-Weekly Income Converted to Monthly Income

$984.76 average bi-weekly income
X 2.15
$2,117.23

The calculation of the Appellant's gross monthly income exceeded the 133% FPL MAGI standard. To be eligible for Adult Group Medicaid benefits, the Appellant's gross monthly income must be equal to or below 133% FPL. For a one-person AG, 100% of the FPL is $1,215 and 133% of the FPL is $1,616. To determine whether the income is below the MAGI standard, the policy instructs the monthly gross income be converted to a percentage of the FPL:

$2,117.23 gross monthly income ÷ $1,215 (100% of the FPL) = 174%

Eligibility Under Other Coverage Groups

When the Appellant's income exceeds the Medicaid eligibility limit, the Respondent may close the AG after considering the Appellant's Medicaid eligibility under other coverage groups and before notifying the Appellant his Medicaid eligibility would end.

During the hearing, the Appellant testified that he required medication related to an HIV diagnosis and should be eligible for Medicaid coverage. Pursuant to the policy, the Aids Drug Assistance Program (ADAP) is not a Medicaid program. During the hearing, the Respondent's representative testified that the Appellant was issued information on how to apply for this program. The Appellant agreed he had received the information.

Pursuant to the policy, when an individual is medically needy and cannot afford to pay their medical bills, they may be eligible for Medically Needy Income Level (MNIL) benefits to assist with the cost of incurring medical expenses. Pursuant to the policy, to qualify for MNIL benefits, criteria must be met for AFDC or SSI-Related Medicaid eligibility. During the hearing, the Respondent's representative testified that the Appellant was mailed applications for MWIN benefit eligibility and information regarding purchasing low-cost healthcare coverage. The

Appellant did not refute that he was provided with this information. No evidence was submitted to indicate that the Appellant would qualify for other Medicaid coverage groups. The preponderance of the evidence indicated the Respondent fulfilled the policy obligation to evaluate the Appellant for Medicaid eligibility before notifying him that his Medicaid eligibility will end.

CONCLUSIONS OF LAW

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

2) The preponderance of the evidence demonstrated the Appellant's gross monthly income was 174% of the FPL.

3) The Respondent correctly terminated the Appellant's Adult Medicaid benefits because his gross monthly income exceeded the Adult Medicaid income eligibility limit for a one-person AG.

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 10th day of August 2023.

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Tara B. Thompson, MLS
State Hearing Officer