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

September 14, 2023

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 23-BOR-2065

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 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,

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

Encl: Decision Recourse
Form IG-BR-29
CC: James Falter, [redacted] DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 23-BOR-2065**

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 July 18, 2023.

The matter before the Hearing Officer arises from the Respondent's May 26, 2023 decision to deny the Appellant Adult Medicaid eligibility because her income exceeded the eligibility limits.

At the hearing, the Respondent was represented by James Falter, [redacted] DHHR. The Appellant appeared and represented herself. Appearing as a witness for the Appellant was [redacted] the Appellant's mother. All those present were sworn in and the following documents were admitted into evidence.

Department's Exhibits:
D-1 Scheduling Notice, dated June 28, 2023
D-2 Hearing Request, dated June 12, 2023
D-3 Notice, dated May 26, 2023
D-4 Employment Income screen-print
D-5 [redacted] paystubs, dated February 24, March 3, March 10, March 17, and March 24, 2023
D-6 West Virginia Income Maintenance Manual (WVIMM) Income Chart
D-7 WVIMM Excerpts
D-8 Case Comments

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) On May 25, 2023, the Appellant applied for Medicaid benefits (Exhibit D-8).

2) On May 26, 2023, the Respondent issued a notice denying the Appellant's eligibility for Medicaid benefits because her income exceeded the Medicaid eligibility limit (Exhibit D-3).

3) The Respondent's decision was based on paystubs submitted to determine the Appellant's March 2023 SNAP eligibility (Exhibit D-8).

4) The Respondent relied upon the Appellant's March 3, March 10, March 17, and March 24, 2023 paystubs to determine her Medicaid eligibility (Exhibits D-4 and D-8).

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 1.2.9 *Addition of a Benefit to an Active Case* provides in relevant sections:

When a member of a SNAP AG applies for Medicaid, a new application form is not required when all [emphasis adds] of the following conditions are met:

- The latest application or redetermination for the existing program or Medicaid coverage group was completed using a DFA-2 or WV PATH application.
- Sufficient information about eligibility requirements for the new program or Medicaid coverage group is on the latest DFA-2 or WV PATH application.
- Verification required for the new program or Medicaid coverage group is contained in or recorded in the eligibility system or the case record.

WVIMM § 7.2.1 *When Verification is Required* provides in relevant sections:

Verification must be requested when the policy requires routine verification of specific information.

WVIMM § 4.3.2 *Countable Sources of Income* provides in relevant sections:

For determining Modified Adjusted Gross Income (MAGI) Medicaid Adult Group eligibility, wages and salaries 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 application 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 he 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 § 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, 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.

DISCUSSION

The Respondent denied the Appellant's Medicaid eligibility because the amount of the Appellant's gross monthly income exceeded the Adult Medicaid eligibility guidelines for a one-person AG. The Appellant disagreed with the decision. The Appellant argued that her income normally fluctuates and contended that the income used by the Respondent was not an accurate reflection of her monthly wages.

To be eligible for Adult Medicaid, the Appellant's gross monthly income could not exceed $1,616. The Respondent bears the burden of proof. To prove that the Respondent correctly denied the Appellant's Adult Medicaid benefits, the Respondent had to demonstrate by a preponderance of the evidence that the Appellant's income exceeded the Medicaid eligibility limit at the time of the Respondent's May 26, 2023 eligibility denial.

The policy requires the Respondent to consider the amount of income received by the Appellant in the thirty days before her application date. Pursuant to the policy, the Respondent must convert the Appellant's gross weekly earned income amount into a monthly amount to determine Medicaid eligibility.

During the hearing, the Respondent testified that the submitted paystubs were used to determine the Appellant's income within the thirty days before her application. The case comments revealed that in March 2023, the Appellant applied for SNAP benefits and submitted income verification for SNAP eligibility on April 7, 2023.

Pursuant to the case comments, the Appellant applied for Medicaid benefits on May 25, 2023. When a benefit is being added to an active case, a new application is required unless the situation meets a series of conditions listed in the policy (WVIMM § 1.2.9). The submitted evidence did not indicate that the Appellant met the criteria necessary to evaluate her Medicaid eligibility without the submission of a new application.

The policy stipulates that benefits may be added to an active case without a new application for the new benefit eligibility when certain criteria are met. In the absence of meeting those criteria, a new application must be submitted to determine the member's eligibility for the added benefit. The submitted evidence did not reveal that the case record contained verification of the Appellant's income in the thirty days preceding her Medicaid application. Pursuant to the policy, when determining Medicaid eligibility using past income, income from the thirty days preceding

the application date must be considered. The evidence did not reveal that the Respondent requested new income verification when the Appellant submitted her Medicaid application.

The policy stipulates that verification is required when the information provided is incomplete or additional information is necessary to determine eligibility. Pursuant to the policy, the Worker must not request verification if the case record or other documentation shows that verification has previously been supplied. Pursuant to the policy, to meet this criterion, the verification required for the new program or Medicaid coverage group must be contained in or recorded in the eligibility system or the case record.

Verification may be requested if the verification provided or shown in the Department's records is incomplete, inaccurate, outdated, or inconsistent with recently reported information. The Appellant's Medicaid application was not supplied as evidence. Therefore, it cannot be affirmed whether the income reported on the Appellant's Medicaid application was incomplete, inaccurate, outdated, or inconsistent with the recently verified income. The Respondent did not offer sufficient explanation during the hearing to clarify why the Respondent did not request new income verification from the Appellant when determining her Medicaid eligibility.

Because the Respondent considered income verified before the Appellant's date of application and not within the thirty days preceding her application date, the matter must be remanded for the Respondent's issuance of a new request for income verification and consideration of the Appellant's income in the thirty days before her Medicaid application. The Appellant retains the right to appeal any subsequent eligibility denial following the submission and consideration of income verification from the thirty days before her Medicaid application.

It should be noted that during the hearing, the Appellant testified that she had difficulty getting mail at times. On the record, the Appellant updated her case to include her email address and the addition of her mother as her case representative to be copied on all correspondence.

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) To determine a monthly amount of income, the Respondent must determine the amount of income received by the applicant in the thirty calendar days before the application date.

3) The preponderance of evidence failed to prove that the Respondent considered the amount of income received by the Appellant in the thirty calendar days before her May 25, 2023 Medicaid application.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Adult Medicaid benefits. The matter is hereby **REMANDED** for issuance of an income verification request, consideration of the Appellant's income in the thirty days before her May 25, 2023 application, and a new determination of the Appellant's Medicaid eligibility at the time of application.

Entered this 14th day of September 2023.

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Tara B. Thompson, MLS
State Hearing Officer