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

October 12, 2023

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 23-BOR-2249

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: Melanie White, [redacted] DHHR

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 23-BOR-2249**

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 August 23, 2023.

The matter before the Hearing Officer arises from the Respondent's July 11, 2023 decision to terminate the Appellant's Adult Medicaid benefits.

At the hearing, the Respondent was represented by Lori Brown, Economic Services Supervisor, [redacted] DHHR. The Appellant appeared and represented herself. Appearing as a witness on behalf of the Appellant was [redacted], the Appellant's Family Nurse Practitioner (FNP). 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, beginning in February 2019.

2) On July 11, 2023, the Respondent issued a notice advising the Appellant her Adult Medicaid benefits would end, on August 1, 2023, because her income exceeded the Adult Medicaid income eligibility limit.

3) The Respondent's decision was based on a one-person Assistance Group (AG).

4) The Appellant is disabled.

5) The Respondent did not evaluate the Appellant for other Medicaid coverage groups before terminating her Adult Medicaid eligibility.

6) The Respondent considered $556.31 in gross earned income wages when determining the Appellant's Adult Medicaid eligibility.

7) The Appellant receives $1,670.50 gross unearned income in life insurance disability income.

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

WVIMM § 4.3 *Charts of Income Sources* provides:

> Chart 2 shows income sources used for calculating the Modified Adjusted Gross Income (MAGI) …. These income sources are the basis of the calculation of the household's MAGI, and therefore apply to the following Medicaid coverage groups: Adult Group, …Chart 2 should not be considered an exhaustive list of income sources that could count toward adjusted gross income.

WVIMM § 4.3.2 *Countable Sources of Income* provides: For determining Modified Adjusted Gross Income (MAGI) Medicaid Adult Group eligibility, disability pension plans paid by an employer, fringe benefits, bonuses, and awards, wages, salaries, and tip income are countable sources of income.

WVIMM §§ 4.7 and 4.7.2 *MAGI Methodology* provides: The MAGI methodology is used to determine financial eligibility for the Medicaid Adult Group.

WVIMM § 4.6.1 *Budgeting Method* provides:

> 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. *Consideration of Past Income* provides:

> 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 …

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

> 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 § 4.7.5.E provides: Regardless of the source, irregular income is not counted because it cannot be anticipated.

WVIMM § 23.10.4 *Adult Group* provides: To be eligible for Adult Group Medicaid benefits, the income must be equal to or below 133% Federal Poverty Level (FPL).

WVIMM Chapter 4, Appendix A *Income Limits* provides: 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.

WVIMM § 23.9 provides:

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 income reported during her eligibility review exceeded the Adult Medicaid eligibility limit. The Appellant contested the Respondent's termination of Adult Medicaid eligibility. The Appellant argued that she requires Adult Medicaid coverage due to her disability status.

The Board of Review is required to follow the policy and cannot change the policy or award eligibility beyond the circumstances provided in the policy. The Respondent bears the burden of proof. To prove that the Appellant was ineligible for Adult Medicaid benefits, the preponderance of evidence had to demonstrate that the Appellant's income exceeded the income eligibility limit for Adult Medicaid. The Respondent also had to prove that the Respondent evaluated the Appellant's eligibility for other Medicaid coverage groups before terminating her Adult Medicaid benefits. During the hearing, neither party submitted documents to be considered for evidential review.

Income

To be eligible for Adult Medicaid, the Appellant's income had to be equal to or below 133% FPL. The only allowable adjustment is a 5% disregard. During the hearing, the Respondent's representative testified that the Appellant completed a Medicaid eligibility review and exceeded the income eligibility limit. The Respondent's July 11, 2023 notice indicated the Appellant's Adult Medicaid benefits were terminated, effective August 1, 2023, because the Appellant's gross monthly income exceeded the Adult Medicaid eligibility limit. The notice revealed that the Appellant considered $555.31 in gross monthly earned income and $1,670.50 in gross monthly unearned income when determining the Appellant's eligibility.

During the hearing, the Appellant's' witness, [redacted], testified that the Appellant receives $1,670 per month unearned disability income. Testimony from the parties indicated that the Appellant works up to two days per week and makes "a little over $100 per week."

The parties' testimony indicated that the Appellant's disability income is not administered by the Social Security Administration and is paid from life insurance aligned through her previous employer. As the policy specifies that fringe benefits and disability pension plans paid by an employer are considered as income for determining MAGI-based Medicaid eligibility, the Respondent correctly included the Appellant's unearned income when determining her Adult Medicaid eligibility. The policy stipulated that wages are counted as earned income when determining MAGI-based Medicaid eligibility; however, the policy specifies that irregular income should be excluded.

While the Appellant's witness's testimony was consistent with the unearned income amount considered by the Respondent when determining the Appellant's Adult Medicaid eligibility, the amount of weekly income reported by the Appellant's witness — $413, when calculated using the weekly method described in WVIMM § 4.6.1.D — conflicted with the $555.31 monthly earned income amount considered by the Respondent.

The policy stipulates that the Respondent must determine the amount of the Appellant's income received in the 30 calendar days before the redetermination date. The Appellant's review form was not submitted for review. The paystubs used by the Respondent to verify the Appellant's income in the 30 calendar days before the Appellant's redetermination were not provided for review. Sufficient evidence was not submitted to rule out whether the earned income used by the Respondent was comprised of irregular wages that should be excluded. Further, the evidence did not establish the date of redetermination. Without this critical corroborating information, the reliability of the earned income amount used by the Respondent to determine the Appellant's Adult Medicaid eligibility could not be confirmed.

The parties agreed on the amount of the Appellant's unearned monthly income. The policy instructs that the AG's income is divided by 100% FPL for the applicable AG size. Then, the policy provides that the amount should be converted to a percentage.

$1,670.5 (monthly unearned income) ÷ 1,215 (100% FPL for one-person AG) = 1.37489 or 137% FPL

After the application of an allowable 5% disregard, the Appellant's unearned income would fall below the eligibility limit of 133%.

137%
- 5%
132%

The Appellant's income eligibility is reliant on the credibility of the earned income amount used by the Respondent. The evidence failed to establish a reliable monthly earned income amount. Therefore, the Respondent must complete a new redetermination to decide her ongoing Adult Medicaid eligibility. The Respondent's representative testified that the Respondent's worker did not assess the Appellant's eligibility for other Medicaid coverage groups. If found to be ineligible for Adult Medicaid, the policy requires the Respondent to evaluate the Appellant's eligibility for other Medicaid coverage groups before terminating her Adult Medicaid.

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 failed to establish the amount of the Appellant's gross monthly income.

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

4) Because the preponderance of the evidence failed to establish the amount of the Appellant's gross monthly income, a new redetermination must be completed to assess the Appellant's ongoing Adult Medicaid eligibility.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Adult Medicaid benefits. It is hereby **ORDERED**, the Appellant's Adult Medicaid eligibility be reinstated to the date of termination. The matter is **REMANDED** for a new Adult Medicaid eligibility determination — based on the Appellant's verified income from the thirty days preceding the new redetermination date.

Entered this 12th day of October 2023.

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Tara B. Thompson, MLS
State Hearing Officer