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 25, 2023

[redacted]

Re: [redacted] v WV DHHR
ACTION NO.: 23-BOR-2361

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,

Angela D. Signore
State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Rebecca Skeens, Department Representative, WV DHHR, [redacted]

BEFORE THE WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES BOARD OF REVIEW

IN THE MATTER OF: **ACTION NO.: 23-BOR-2361**

[redacted]

Appellant,

v.

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 (WV) Department of Health and Human Resources' (DHHR) Common Chapters Manual. This fair hearing was convened on August 23, 2023, on an appeal filed July 26, 2023.

The matter before the Hearing Officer arises from the July 19, 2023 determination by the Respondent to deny the Appellant Adult Medicaid eligibility due to income exceeding the eligibility limits.

At the hearing, the Respondent appeared by Rebecca Skeens, Economic Service Worker, WV DHHR, [redacted]. The Appellant appeared *pro se*. Both witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 WV PATH eligibility system printout of Case Comments, dated May 04, 2023 through July 18, 2023
D-2 Copy of [redacted], dated June 21, 2023
D-3 WV PATH Employment Income Screen Print
D-4 Notice of Decision, dated July 19, 2023
D-5 West Virginia Income Maintenance Manual (WVIMM) §§ 4.5.1.C, 4.5.1.D
D-6 WVIMM § 4.4.1.F

Appellant's Exhibits:

A-1 Physician Letter regarding [redacted], dated June 21, 2023
A-2 Civil Judgement Order for [redacted], signed by [redacted], dated August 03, 2023

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 Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) On July 18, 2023, the Appellant submitted an application for Adult Medicaid program benefits for an assistance group (AG) of one (1). (Exhibit D-1)

2) At the time of application, the Respondent verified the Appellant's submitted income was reflective of her normal pay. (Exhibit D-1)

3) The Appellant's total monthly gross income is $2,087.24. (Exhibit D-3)

4) The maximum monthly gross income limit for Adult Medicaid program benefits for a one (1) person AG is $1,616, or 133% of the Federal Poverty Level (FPL). (Exhibit D-4)

5) On July 19, 2023, the Respondent issued a notice advising the Appellant that her eligibility for Adult Medicaid program benefits was denied, due to the Appellant's income exceeding the eligibility limit established by policy. (Exhibit D-4)

6) The Appellant contested the Respondent's decision and requested a Fair Hearing on July 31, 2023.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 4 Appendix A provides, in part:

> For a one (1) person Assistance Group (AG), the income limit is $1,616 = 133% FPL
> For a one (1) person Assistance Group (AG), 100% of the FPL = $1,215

WVIMM § 4.3.2 provides, in part:

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

WVIMM § 4.6.1 provides, in part:

> 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 provides, in part:

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.

WVIMM § 4.6.1.B provides, in part:

The Worker must consider information about the client's income sources before deciding which income to use. The Worker must follow the steps below for each old income source.

Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days prior to the application/redetermination date. The appropriate time period is determined by counting back 30 days beginning with the calendar day prior to the date of application/redetermination. The income from this 30-day period is the minimum amount of income that must be considered. When, in the Worker's judgment, future income may be more reasonably anticipated by considering the income from a longer period of time, the Worker considers income for the time period he determines to be reasonable. Whether the Worker considers income from the prior 30 days, or from a longer period of time, all of the income received from that source during that time period must be considered. All pay periods during the appropriate time period must be considered and must be consecutive.

Step 2: Determine if the income from the previous 30 days is reasonably expected to continue into the new certification period or POC. If it is not expected to continue, the income from this source is no longer considered for use in the new certification period or POC. If it is expected to continue, determine if the amount is reasonably expected to be more or less the same. If the income is expected to continue, the income source is used for the new certification period or POC and treated according to How to Use Past and Future Income below. If it is not expected to continue at more or less the same amount, the income source is used for the new certification period or POC and treated according to Consideration of Future Income below.

Step 3: Record the results of Step 2, including the amount of income, why the source is or is not being considered for the new certification period or POC, the client's statement about continuation of the income from this source, the time period used, and, if more than the previous 30 days, the reason additional income was considered. Once the Worker has determined all the old sources of income to consider and the time period for which they are considered, he must then determine if any source should be considered for future income.

WVIMM § 4.6.1.D provides, in part:

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 provides, in part:

The Modified Adjusted Gross Income (MAGI) methodology is used to determine financial eligibility for the Adult Medicaid group.

WV IMM § 4.7.4 Determining Eligibility provides, in part:

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

Step 1: Determine the MAGI-based gross monthly income for each MAGI household income group (IG).

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 results from Step 2 is equal or less than the appropriate income limit (133% FPL), no disregard is necessary, and no further steps are required.

The adjusted gross income is then compared to the 133% of the FPL for the appropriate AG size to determine eligibility for MAGI Medicaid.

WVIMM § 23.10.4 Adult Group Income Guidelines provides, in part:

As a result of the Affordable Care Act (ACA), the Adult Group was created,

effective January 1, 2014. Eligibility for this group is determined using MAGI methodologies established in Section 4.7. Medicaid coverage in the Adult Group is provided to individuals who are aged 19 or older and under age 65.

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

DISCUSSION

On July 18, 2023, the Appellant submitted an application for Adult Medicaid program benefits for an assistance group (AG) of one (1). On July 19, 2023, the Respondent issued a Notice of Denial advising the Appellant that her income exceeded the allowable limit established by policy to receive Adult Medicaid benefits. The Appellant contested the Respondent's decision and on July 31, 2023, requested a Fair Hearing. The Respondent bears the burden of proof to establish that the action taken against the Appellant was in accordance with policy.

To be eligible for Adult Medicaid benefits for a one (1) person AG, the Appellant's gross monthly income could not exceed $1,616. 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 established by policy at the time of the Respondent's July 19, 2023, decision. In order to determine Adult Medicaid program eligibility, policy requires the Respondent to consider the amount of income received by the Appellant in the thirty (30) days prior to the date of application. The Respondent must convert the Appellant's gross bi-weekly earned income amount into a monthly amount to determine Medicaid eligibility. At the time of the hearing, the Respondent testified the amount of income reflected on the Appellant's paystubs ($970.81) was considered when determining the Appellant's Adult Medicaid benefit eligibility.

The Appellant argued that while her employer may schedule her for a full-time, forty (40) hour work week, she does not always work the forty (40) hours that was reflected on the paycheck used by the Respondent in consideration of her eligibility for Medicaid benefits. The Appellant testified that, due to her multiple medical problems, she was provided a "doctor's intermittent" note for times when she is not physically able to attend work due to her health. She further testified that, not only can she not afford the medical insurance offered by her employer, but that she is behind on her monthly rent and is facing eviction proceedings. However, because the policy does not provide any exceptions based on the Appellant's ability to afford healthcare absent Medicaid benefits, this Hearing Officer is unable to award any income exclusions or eligibility exceptions.

The Respondent testified that at the time of application, and at the time of the pre-hearing conference, the Appellant attested to the reported bi-weekly gross income amount of $970.81 as being the normative. The Respondent concluded her testimony by informing the Appellant that if the Appellant could provide the Department with additional verification of income fluctuation, the Respondent can reassess her Medicaid eligibility. However, because the Appellant provided no further income verifications prior to the hearing, this Hearing Officer's decision must be solely based on the evidence and testimony provided at the time of the hearing. No evidence was entered to verify that the Appellant was eligible for any deductions allowed by policy.

As established by the policy, the steps to determine the Appellant's monthly countable income for Adult Medicaid program benefit purposes are as follows: Bi-weekly amount ($970.81) x 2.15 =

$2,087.24. A 5% disregard is applied if the deduction would bring the AG's income below the 133% FPL income limit. To determine if the Appellant is eligible for the 5% disregard, her monthly income is divided by 100% ($1,215) of the FPL: $2,087.24 ÷ $1,215 = 1.71. The Appellant's FPL is then converted to a percentage: 1.71 = 171%. Because the application of the 5% disregard would not bring the Appellant's income below the 133% FPL policy requirement, the disregard cannot be applied. Because the Appellant's gross monthly income amount of $2,087.24 exceeds the 133% FPL as established by policy, the Respondent correctly denied the Appellant's Adult Medicaid application.

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) For a one (1) person Assistance Group (AG), the income limit is $1,616.

3) The Appellant's income amount of $2,087.24 exceeded the 133% FPL for a one (1) person Adult Medicaid AG.

4) The Respondent correctly denied the Appellant's Adult Medicaid benefit application due to the Appellant's income exceeding Medicaid eligibility guidelines.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's application for Adult Medicaid benefits.

ENTERED this _____ day of September 2023.

_____

Angela D. Signore
State Hearing Officer