STATE OF WEST VIRGINIA
OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

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

Christopher G. Nelson
Interim Inspector General

February 7, 2024

[redacted]

RE: [redacted] v. WV DEPARTMENT OF HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE
ACTION NO.: 23-BOR-2401

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 Human Services. 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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

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

cc: Michael Jackson, Assistant Attorney General

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WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 23-BOR-2401**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE,

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 Office of Inspector General Common Chapters Manual. This fair hearing was convened on January 22, 2024.

The matter before the Hearing Officer arises from the July 19, 2023, decision by the Respondent to terminate Adult Medicaid benefits.

At the hearing, the Respondent appeared by Michael Jackson, Esquire, Assistant Attorney General. Appearing as witnesses for the Respondent were Cindy Mann, Economic Services Supervisor; Heather Walker, Economic Services Supervisor; Karry Evans, Economic Service Worker and Penny Bannister, Economic Service Worker. The Appellant appeared by counsel, [redacted], Legal Aid of WV. Appearing as a witness for the Appellant was her husband, [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Hearing Request Notification Form and Hearing Request received July 27, 2023
D-3* Case Comments
D-4 Case Benefit Summary Screens
D-5 Internal Revenue Service (IRS) Form 1095-B mailed on January 22, 2019, and Notice of Approval dated July 24, 2019
D-6 Medicaid Review Form (unsigned copy) dated August 12, 2019, and Notice of Termination dated September 18, 2019

D-7 Notice of Approval dated February 18, 2020, and IRS Form 1095-B mailed on February 18, 2020
D-8 Medicaid Review Form (unsigned copy) dated June 15, 2020
D-9 Medicaid Review Form (unsigned copy) dated January 11, 2021
D-10 Notice of Approval dated January 28, 2021
D-11 Medicaid Review Form (unsigned copy) dated January 18, 2022
D-12 IRS Form 1095-B mailed on January 24, 2022, and Notice of Approval (Medicaid) and Notice of Denial (SNAP) dated June 17, 2022
D-13 IRS Form 1095-B mailed on January 23, 2023
D-14 Medicaid Review Form (unsigned copy) dated June 12, 2023
D-15 Notice of Termination dated July 19, 2023
D-16 Notice of Approval dated August 9, 2023
D-17 Notice of Approval dated September 20, 2023
D-18 Notice of Approval dated September 27, 2023
D-19 West Virginia Income Maintenance Manual §4.7
D-20 Medicaid Review Form received July 14, 2023
D-21 Paystubs for Appellant dated July 20 and August 3, 2023, and for [redacted] dated August 9, 2023

***** Exhibit D-2 was not admitted into evidence

Appellant's Exhibits:

A-1 Letter from [redacted] dated November 6, 2023
A-2 Letter from [redacted] dated August 31, 2023
A-3 Letter from [redacted] dated October 12, 2023
A-4 Paystubs for [redacted] dated June 14, June 28, July 12, August 9, August 23, September 6, September 20, October 18, 2023, and Letter from [redacted] dated August 29, 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) The Appellant was a recipient of Modified Adjusted Gross Income (MAGI) Adult Medicaid benefits for herself and her husband, [redacted], and Children's Medicaid benefits for their son, [redacted]

2) A Medicaid review form (Form MREV) was submitted to the Respondent on July 14, 2023, on the Appellant's behalf by her authorized representative (Exhibit D-20).

3) The Medicaid review form included pre-populated information regarding the Appellant's household members and income. The form instructed recipients to add any missing information or if any information had changed, add the correct information (Exhibit D-20).

4) The Medicaid review form listed earned income for the Appellant from [redacted] of $1,152 paid twice a month and working an average of 45 hours weekly and earned income for [redacted] of $800 paid every two weeks and working an average of 40 hours weekly (Exhibit D-20).

5) No changes or corrections were made to the Medicaid review form and eligibility was determined based upon the information provided.

6) The Respondent calculated the combined income of the Appellant and [redacted] as $4,024 monthly (Exhibit D-15).

7) The Respondent issued a notice on July 19, 2023, advising the Appellant that Adult Medicaid benefits for herself and [redacted] would be terminated effective July 31, 2023, due to excessive income (Exhibit D-15).

8) The July 19, 2023, notice advised that coverage for [redacted] would continue under WV CHIP, effective August 1, 2023 (Exhibit D-15).

9) The Appellant submitted a hearing request on July 27, 2023, to appeal the termination of Adult Medicaid benefits for herself and [redacted] and the change in coverage for [redacted] from Medicaid to WV CHIP. The Appellant requested a continuation of benefits pending the outcome of the hearing (Exhibit D-1).

10) On August 8, 2023, Adult Medicaid and Children's Medicaid benefits were reinstated for the Appellant, [redacted] pending the outcome of the hearing (Exhibit D-16).

APPLICABLE POLICY

West Virginia Income Maintenance Manual §3.7 explains the eligibility determination groups for Adult Medicaid:

3.7 Adult Medicaid Group

The Patient Protection and Affordable Care Act, amended by the Health Care and Education Reconciliation Act of 2010, enacted March 30, 2010, are together referred to as the Affordable Care Act (ACA). The ACA established the categorically mandatory coverage group known as the Adult Group. Effective January 1, 2014, Medicaid coverage is provided to individuals age 19 or older and under age 65 who are not otherwise eligible for and enrolled in another categorically mandatory Medicaid coverage group, and are not entitled to or enrolled in Medicare Part A or B. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies.

3.7.2 MAGI Household Income Group (IG)

Income of each member of the individual's MAGI household is counted. The income group is determined using the MAGI methodology established in Section 3.7.3.

EXCEPTION: Income of children, or other tax dependents, who are not expected to be required to file an income tax return is not counted, whether or not the individual actually files a tax return.

3.7.3 MAGI Household Needs Group (NG)

The needs group is the number of individuals included in the MAGI household size based upon the MAGI rules for counting household members. To determine the MAGI household size, the following step-by-step methodology is used for each applicant**.** In the case of married couples who reside together, each spouse must be included in the MAGI household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse. The MAGI household of the pregnant woman also includes her unborn child(ren).

This methodology must be applied to each applicant in the MAGI household separately:

STEP 1: IS THE APPLICANT A TAX FILER (and will NOT be claimed as a tax dependent)?
IF NO: Move to **STEP 2**.
IF YES: The applicant's MAGI household includes themselves, each individual he expects to claim as a tax dependent, and his spouse if residing with the tax filer. This is known as the tax filer rule.

STEP 2: IS THE APPLICANT CLAIMED AS A TAX DEPENDENT ON SOMEONE ELSE'S TAXES?
IF NO: Move to **STEP 3.**
IF YES: Test against the three exceptions below. If the answer to any of these exceptions is 'yes', then the applicant's MAGI household size must be calculated using STEP 3.

- The applicant is claimed as a dependent by someone other than a spouse or parent.
- The applicant is a child under 19 who lives with both parents, but both parents do not expect to file taxes jointly.
- The applicant is a child under 19 who is claimed as a tax dependent to a non-custodial parent(s).

If none of these exceptions are true, then the applicant's Medicaid household consists of the applicant, the tax filer claiming him as a dependent, this could be two people filing jointly, any other dependents in the tax filer's household, and the applicant's spouse if they reside together. This is known as the tax dependent rule.

STEP 3: IF THE APPLICANT IS NOT A TAX FILER, IS NOT CLAIMED AS A TAX DEPENDENT OR MEETS ONE OF THE EXCEPTIONS IN STEP 2:

- The Medicaid household consists of the applicant and the following individuals as long as they reside with the applicant:

- The applicant's spouse;
- The applicant's child(ren) under age 19;
- For applicants under 19, their parents, and their siblings who are also under 19.

This is known as the non-filer rule.

STEP 4: CASES WHERE APPLICANT CANNOT REASONABLY ESTABLISH TAX DEPENDENT STATUS: If an applicant/tax filer cannot reasonably establish that reported household members will be tax dependents of the applicant for the tax year in which Medicaid is sought, the inclusion of such individual in the MAGI household of the tax filer is determined using rules in STEP 3.

West Virginia Income Maintenance Manual §4.6 explains the budgeting method for Medicaid:

4.6.1 Budgeting Method

The following method is used to determine income for the certification period or period of consideration (POC), unless information to the contrary is shown in the remaining sections of this chapter. Eligibility is determined on a monthly basis. Therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. The following information applies to earned and unearned income. For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the assistance group (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. When the amount of an anticipated income source is determined by use of an income tax return, it is not necessary to change the method by which that income source is anticipated at each redetermination prior to the next tax return, unless the anticipated income from that source for the upcoming certification period or POC is expected to change.

4.6.1.A Methods for Reasonably Anticipating Income

There are two methods for reasonably anticipating the income the client expects to receive. One method uses past income, and the other method uses future income. Both methods may be used for the same AG for the same certification period. The method used depends on the circumstances of each source of income. 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 or POC.
- 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 exist for a source of income:

- Income from a new source is expected to be received in the certification period or POC. 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 or POC. Income that normally fluctuates does not require use of future income.

4.6.1.B Consideration of Past Income
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.

4.6.1.C Consideration of Future Income
This section applies only when the client reasonably expects to receive income from a new source during the new certification period or POC, or when the amount of income from an old source is expected to change. In that case, the Worker must consider the income that can be reasonably expected to be received.

Step 1: Determine if the IG expects to receive income from a new source, or expects a different amount from an old source, in the new certification period or POC. If not, none of the

following steps are necessary. However, the Worker must record the client's statement that he does not expect income from a new source.

Step 2: Determine the amount of income the client reasonably expects to receive from the new source, or the new amount from the old source. If the amount of income is not reasonably anticipated, the income from that source is not counted. If it is possible to reasonably anticipate a range of income, the minimum amount that is anticipated is used. The Worker will record case comments for the client's statement concerning this income and will also record why it cannot be reasonably anticipated.

Step 3: Determine when the client can be reasonably expected to receive income from the new source or the changed amount from the old source. If the date of receipt cannot be reasonably anticipated, income from this source is not considered. The Worker must record the client's statement that he expects income from a new source or a change in the amount from an old source. In addition, the Worker must record why the date of receipt cannot be anticipated and information about attempts made to determine the date of receipt.

Step 4: When the amount and date of receipt can be anticipated, the Worker treats the income according to How to Use Past and Future Income below.

The Worker must record how the amount and date of receipt were projected.

4.6.1.D How to Use Past and Future Income

After the Worker determines all of the income sources that are to be considered for use, the Worker determines the amount of monthly income, based on the frequency of receipt and whether the amount is stable or fluctuates. This is described below.

When the Frequency of Receipt is:	When the Amount is Stable:	When the Amount Fluctuates:
Monthly	Use actual monthly amount	Use average monthly amount
More often than monthly	Convert amount per period to monthly amount	Find average amount per period and convert to monthly amount
Less often than monthly	Prorate to find amount for intended period. If not monthly, convert or prorate amount	Prorate to find amount for intended period. If monthly, convert or prorate amount

The purpose of finding an average amount of fluctuating income is to even out the highs and lows in the amount of income. The client is not, then, required to report fluctuating income each pay period and the Worker is not required to change income monthly. Should the client report fluctuations in the amount of income, the Worker is only required to recalculate the countable income when, in his judgment, the fluctuation will affect eligibility. All changes reported by the client must be considered, but not necessarily used. Reported changes must be recorded and the Worker must record why the reported income was or was not used.

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

West Virginia Income Maintenance Manual §4.7 explains MAGI Methodology:

4.7.1 Determining Income Counted for the MAGI Household
Income of each member of the individual's MAGI household is counted. The MAGI household is determined using the MAGI methodology established in Chapter 3.

4.7.3 MAGI-Based Income Disregard
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.

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

Step 3: If the result from Step 2 is greater than the appropriate limit (133% FPL), 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.

4.7.5.E Irregular Income
Regardless of the source, irregular income is not counted because it cannot be anticipated.

West Virginia Income Maintenance Manual Chapter 1 explains the application/redetermination process:

1.2.11 Redeterminations
Medicaid and WVCHIP: If coverage is closed for failure to submit a redetermination form, or necessary information, but the client responds and provides the information within 90 days of the effective date of closure, the Worker must determine eligibility in a timely manner without requiring a new application. Eligibility may be back dated up to three months, provided all eligibility requirements were met.

West Virginia Income Maintenance Manual Chapter 10 explains case maintenance procedures:

10.6.5.B Consideration of Eligibility under Other Coverage Groups
In no instance is Medicaid under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. A child is also evaluated for WV CHIP eligibility when Medicaid under one coverage group ends. This evaluation is done before the client is notified that his Medicaid eligibility will end. Eligibility is evaluated based on case record information. The client may be required to visit the office only for completion of a Social Summary for a Medical Review Team (MRT) referral. The AG does not remain active while the MRT decision is pending.

West Virginia Income Maintenance Manual Chapter 4 Appendix A lists the following income limits:

100% FPL for a three-person assistance group: $2,072
133% FPL for a three-person assistance group: $2,756

Centers for Medicare and Medicaid Services State Health Official Memorandum Number 22-001 explains the continuous Medicaid coverage unwinding process:

Aligning Renewals for all Individuals in a Household
States may choose to align work on renewals for all members in a household during the 12-month unwinding period. This strategy will minimize the beneficiary burden by allowing families to receive one request for information from the state. Centers for Medicare and Medicaid Services (CMS) reminds states that, while states may process renewals for an entire household at the same time, redeterminations of eligibility are made on an individual basis. Thus, a state may not terminate coverage for one member whose eligibility is verified with information available to the state because the state was not able to verify eligibility for another member in the household.

Offer a Reconsideration for Coverage Losses following Changes in Circumstances
States may offer a minimum 90-day reconsideration period, similar to the reconsideration period provided for MAGI beneficiaries at renewal under 42 C.F.R. §§435.916(a)(3)(iii) and 457.343, for beneficiaries whose eligibility has been terminated for failure to respond to a request for information needed to redetermine eligibility following a change in circumstances, if the individual subsequently returns the needed information. Offering a reconsideration period allows states to reconsider an individual's eligibility without requiring the individual to fill out a new application. The required information returned within the reconsideration period serves as an application. If adopted, a determination or denial of eligibility based on

the returned information must be made consistent with timeliness standards specified in §435.912 or §457.340(d), as applicable. In Medicaid, retroactive eligibility would be available, consistent with §435.915(a), to provide coverage for up to three months prior to the date the information was returned. States would also need to ensure they collect any additional information from the individual that is not available to the state but required at application, such as a signature.

Centers for Medicare and Medicaid Services State Health Official Memorandum Number 23-002:

Compliance with Federal Renewal Requirements
Federal requirements related to redeterminations of eligibility are described at 42 CFR §435.916. Under federal regulations at §435.916, states must comply with the following requirements:

- Ex Parte Renewals: Begin the renewal process for all beneficiaries, including both those whose financial eligibility is based on modified adjusted gross income (MAGI) ("MAGI-based beneficiaries") and those whose financial eligibility is not based on MAGI ("non-MAGI beneficiaries"), by redetermining eligibility without requiring information from the individual, if the state is able to do so based on reliable information contained in the individual's account or more current reliable information available to the state. This information may include, but is not limited to, information accessed through data sources, consistent with the state's verification plan;
- Renewal Form: Provide a renewal form that requests only information needed to determine eligibility when eligibility cannot be renewed on an ex parte basis. This form must be pre-populated for MAGI-based beneficiaries;
- Reasonable Timeframe and Modalities to Return Form: Provide MAGI-based beneficiaries with a minimum of 30 days to return their pre-populated renewal form and any requested information. Provide non-MAGI beneficiaries with a reasonable period of time to do so. Beneficiaries must be able to return their renewal form through any of the modes of submission described at §435.907(a) (online, by phone, by mail, or in-person);
- Determine Eligibility on All Bases: Consider all bases of Medicaid eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage;
- Advance Notice and Fair Hearing Rights: Provide a minimum of 10 days' advance notice and fair-hearing rights prior to terminating or reducing Medicaid eligibility, in accordance with §435.917 and 42 CFR Part 431, Subpart E;
- Assess Eligibility for Other Insurance Affordability Programs (IAPs) and Transfer Accounts as Appropriate: For individuals determined ineligible for Medicaid, assess eligibility for other IAPs (including CHIP, BHP, and qualified health plans (QHPs) offered through a Health Insurance Marketplace® with advance payments of premium tax credits or cost-sharing reductions), and transfer the individual's account to the appropriate program. States with Marketplaces that use the federal eligibility and enrollment platform are reminded that they should only transfer accounts to the Marketplace for individuals about whom the state has sufficient information to determine Medicaid and CHIP ineligibility. States with Marketplaces that use the federal eligibility and enrollment platform should not transfer accounts to the Marketplace for individuals whose Medicaid or CHIP coverage is terminated for procedural reasons, such as failure to return a renewal

form or other requested information needed to determine eligibility. States that operate State-based Marketplaces using their own platform may, at state option, transfer accounts to the Marketplace for a determination of advance payments of premium tax credits or cost-sharing reductions for individuals whose coverage has been terminated from Medicaid or CHIP for procedural reasons; and

- Reconsideration Period: Reconsider eligibility without requiring a new application for MAGI-based beneficiaries whose coverage is terminated for failure to return their renewal forms or necessary information if the individual's renewal form or information is returned within 90 days (or longer if elected by the state) after coverage is terminated. States may, at their option, apply this policy to non-MAGI beneficiaries.

DISCUSSION

Policy stipulates that the income limit for MAGI Adult Medicaid is 133% of the federal poverty level for the size of the assistance group. A 5% disregard is applied if the deduction would bring the assistance group's income below the 133% federal poverty level income limit.

The Appellant underwent a Medicaid eligibility redetermination in July 2023. The Respondent terminated Adult Medicaid benefits for the Appellant and her husband due to excessive income and terminated Children's Medicaid benefits for the Appellant's son. The Appellant's son was evaluated for and approved for WV CHIP. It should be noted that although the Appellant initially contested [redacted] change in coverage from Medicaid to WV CHIP, counsel for the Appellant indicated this issue was no longer under appeal. [redacted] eligibility for Medicaid will not be discussed in this decision.

The Appellant submitted a Medicaid review form to the Respondent on July 14, 2023. The pre-populated form listed earned income for the Appellant of $1,152, paid twice a month, and earned income for [redacted] of $800, paid every two weeks. The Appellant did not alter or make corrections to the Medicaid review form and continued Medicaid eligibility was determined using the information provided by the Appellant. The Respondent calculated the combined gross income for the Appellant and [redacted] as $4,024, which exceeds the income limit of $2,756 for a three-person assistance group for Adult Medicaid benefits.

Penny Bannister, caseworker for the Respondent, testified that she processed the July 14, 2023, Medicaid review form for the Appellant. Ms. Bannister stated that because there were no changes made to the review form, the income amounts listed in the case record that were pre-populated on the review form, eligibility was determined using those amounts. Ms. Bannister stated the Respondent's electronic eligibility system uses information in the case record to determine potential eligibility for other Medicaid categories, which determined WV CHIP eligibility for [redacted] when the income was excessive for Children's Medicaid benefits.

The Appellant, by counsel, submitted a statement from the Appellant's employer to the Respondent advising that the Appellant's pay frequency changed from semi-monthly to bi-weekly, effective March 2023. The Appellant received extra compensation in March, April, May and June 2023 to offset the change in pay frequency and her July 6, 2023, paycheck included the final

installment of the additional money (Exhibit A-4). Counsel for the Appellant provided the Appellant's paystub dated July 20, 2023, for $1,069.32 and paystubs for [redacted] (Exhibit A-4):

June 14	$507.30 (50.73 hours)
June 28	$767.30 (76.73 hours)
July 12	$626.95 (61.89 hours)
July 26	$926.75 (paystub was not provided, year-to-date was used to determine amount)
August 9	$775.45 (59.65 hours)
August 23	$509.47 (39.19 hours)
September 6	$698.88 (53.76 hours)
September 20	$920.79 (70.72 hours)
October 4	$0 (did not work this pay period)
October 18	$399.36 (30.72 hours)

Cindy Mann, Economic Services Supervisor, testified that she reviewed the income that was provided by the Appellant's counsel and entered the updated information into the Respondent's electronic eligibility system. Ms. Mann testified that took an average of all ten paystubs provided to determine a monthly amount for [redacted] Ms. Mann stated that in using the updated income that was submitted, the total combined income continued to exceed the allowable limit for Adult Medicaid benefits.

The Appellant, by counsel provided the Respondent with statements from [redacted] physicians documenting a seizure condition and his inability to work post-seizure. The August 31, 2023, statement from [redacted] indicated that [redacted] was unable to work for a few days after recovering from a seizure and the October 12, 2023, statement from [redacted] noted that [redacted] was unable to work 3-4 days post-seizure. A statement from [redacted] dated November 6, 2023, noted that [redacted] would be off from work for the following two weeks due to a change in his medications (Exhibits A-1, A-2 and A-3).

[redacted] testified that he has a seizure disorder, and he experiences body pain post-seizure that affects his ability to work. As a result of his medical condition, [redacted] stated his income and hours worked fluctuated. [redacted] stated after a seizure in October, he was unable to return to work for several weeks and eventually lost his job. [redacted] testified that he is no longer working and now receives Unemployment Compensation of $198 weekly.

The Appellant testified that she spoke with a caseworker for the Respondent sometime in November about Medicaid benefits for [redacted] The Appellant purported that she was advised by the Respondent that they were not eligible for additional benefits but she received a Medicaid application by mail, which she did not complete and return.

Counsel for the Appellant argued that because [redacted] income was irregular and could not be anticipated, it should not have been counted in redetermining Adult Medicaid eligibility. Counsel claimed that the Respondent failed to consider a change in the [redacted] income due to his medical condition and the Respondent was required to consider his income in the 90-day period of consider post-termination without the submission of a new application per Medicaid unwind procedures established by CMS. Furthermore, counsel contended that [redacted] was not evaluated for potential

eligibility in other Medicaid categories prior to the termination of MAGI Adult Medicaid benefits.

Pursuant to policy and federal regulations, eligibility may be reconsidered without requiring a new application for MAGI Medicaid groups whose coverage was terminated for failure to return a renewal form or necessary information if the individual's renewal form or information is returned within 90 days after coverage is terminated. The Appellant submitted the Medicaid review prior to the end of the certification period and reported no changes to her household's income. Although counsel for the Appellant argued that the Respondent was required to consider the change in the Appellant's household income in the 90-day period subsequent to the Adult Medicaid closure, the Respondent was not obligated to consider the income that was provided in the months during the pendency of the hearing as the Medicaid termination was due to excessive income and not for failure to complete an eligibility review or failure to provide necessary verification. However, due to a continuation of benefits that were requested pending the hearing decision, the Respondent evaluated the Appellant's household based on the reported change in circumstances.

The Appellant provided documentation confirming an anticipated decrease in [redacted] hours worked due to his seizure condition. The paystubs submitted for [redacted] after the proposed termination of Adult Medicaid benefit showed fluctuating hours each pay period. The Respondent used an average of all paystubs submitted for [redacted] that showed fluctuating income to determine continued eligibility and determined the income remained excessive for Adult Medicaid benefits.

Using the income submitted by the Appellant, her and [redacted] income was calculated as: $6,132.25 divided by 10 equals $613.22 multiplied by 2.15 equals $1,318.43 averaged monthly income for [redacted] The Appellant's income of $1,069.32 was multiplied by 2.15 to determine a monthly amount of $2,299.03. The total combined income for the Appellant and [redacted] using the updated income provided was $3,617.46. To determine if the 5% disregard is applied, the household's gross monthly income is converted to a percentage of the federal poverty level by dividing the current monthly income by 100% of the federal poverty level for the household size. The result is converted to a percentage: $3,617.46 divided by $2,072 = 1.74 converted to a percentage of 174%. The application of the 5% deduction would not bring the household below 133% of the federal poverty level.

Policy stipulates that eligibility is determined on a monthly basis, 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 assistance group and past income is used only when it reflects the income the client reasonably expects to receive during the certification period. Counsel for the Appellant argued that [redacted] income should not have been counted in eligibility calculations because it was irregular income. According to the budgeting method found in policy, past income is only used when income is expected to continue into the certification period and the amount of income from the same source is expected to be more or less the same. Future income is used when income from a new source is expected to be received in the certification period or the rate of pay or the number of hours worked for an old source is expected to change during the certification period.

The Respondent considered the paystubs provided for [redacted] that showed fluctuating hours to determine continued eligibility. Based on the paystubs provided, the income exceeded the limit for

Adult Medicaid benefits. [redacted] continued to receive income from his employer, although fluctuating, and must therefore be considered in determining eligibility.

The Respondent evaluated the Appellant's household for other Medicaid coverage groups at the time of the July 2023 redetermination based upon the information contained in the case record. The Appellant and [redacted] were found ineligible for other Medicaid groups and [redacted] was found eligible for WV CHIP. Information regarding [redacted] medical condition was not provided to the Respondent until after the Adult Medication termination, therefore he would not have been evaluated for a disability-related coverage group at the time of the July 2023 review form was processed. In the months following the Adult Medicaid termination, [redacted] should have been evaluated for a disability-related Medicaid coverage group by referral to the Medical Review Team. The Appellant testified that she received a Medicaid application by mail that she did not return, therefore it is unknown whether this application would have initiated the disability referral process.

The Respondent evaluated the Appellant and [redacted] for continued Medicaid eligibility based upon the change in income that was reported using the paystubs that were provided. The income continued to be excessive for Adult Medicaid benefits. Whereas the combined income of the Appellant and [redacted] exceeded the allowable limits found in policy, the Respondent's proposal to terminate Adult Medicaid benefits is affirmed.

CONCLUSIONS OF LAW

1) The income limit for MAGI Adult Medicaid benefits is 133% of the federal poverty level, or $2,576 for a three-person assistance group.

2) The Respondent calculated the Appellant's household income as $4,024 based on the information provided on the July 14, 2023, review form.

3) The income exceeded the allowable limit for Adult Medicaid benefits and notice was sent advising of the termination.

4) Subsequent to the termination, the Appellant reported a reduction in income due to [redacted] medical condition and reduced hours of work.

5) Paystubs for [redacted] from June through October 2023 were provided to the Respondent for reconsideration of eligibility.

6) Based on the income provided, the combined income of the Appellant and [redacted] continued to exceed the allowable income limit.

7) The Respondent correctly determined the Appellant's household income to be excessive for continued Adult Medicaid eligibility.

DECISION

It is the decision of the State Hearing Officer to **uphold** the proposal of the Respondent to terminate MAGI Adult Medicaid benefits for the Appellant and [redacted].

ENTERED this 7th day of February 2024.

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Kristi Logan
Certified State Hearing Officer