March 18, 2025

REMOVED

RE: REMOVED v. WVDOHS
ACTION NO.: 25-BOR-1209

Dear REMOVED

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 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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

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

cc: Jennifer Patton, Department Representative
Charles Cline, Department Representative

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

REMOVED

Appellant,

v. **Action Number: 25-BOR-1209**

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 REMOVED. 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 March 4, 2025, upon a timely appeal filed on January 27, 2025.

The matter before the Hearing Officer arises from the December 27, 2024 decision by the Respondent to deny Medicaid benefits due to excessive income and failure to meet a spenddown.

At the hearing, the Respondent appeared by Jennifer Patton. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 West Virginia Income Maintenance Manual (excerpts)

D-2 West Virginia Income Maintenance Manual (excerpts)

D-3 Notice of decision, dated December 27, 2024

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 Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant applied for Medicaid as a household of one (1).

2) The Appellant was considered for "buy-in," or categories of Medicaid referred to as Medicare Premium Assistance (MPA).

3) The Respondent mailed the Appellant a notice dated December 27, 2024 (Exhibit D-3), advising the Appellant that she was denied for MPA because "Income is more than the income limit for you to receive benefits."

4) The notice (Exhibit D-3) additionally noted that the Appellant was evaluated for Medicaid coverage by meeting a "spenddown" – or countable medical bills that exceed an income-based threshold – and denied for insufficient medical bills to meet that threshold.

5) The Respondent verified two (2) sources of income for the Appellant: Social Security income, and income from a pension.

6) The Appellant did not dispute the number or type of income sources.

7) The Respondent verified the amount of the Appellant's Social Security income using a data exchange with the Social Security Administration.

8) The Respondent verified the Appellant's monthly Social Security income as $1566.70.

9) The Appellant did not dispute the amount of Social Security income verified by the Respondent.

10) The Appellant reported, but did not verify the monthly income from her pension as $253.

11) The Appellant did not dispute the monthly pension amount of $253 used by the Respondent in its determination of the Appellant's gross unearned income amount ($1819.70), or its determination of the Appellant's countable net income ($1799.70) (Exhibit D-3).

12) The Appellant did not dispute the Respondent's income determination, the Respondent's calculation of the spenddown amount ($9598.20) (Exhibit D-3), or the Respondent's determination that the Appellant did not verify medical bills to meet the spenddown threshold.

13) The Appellant requested an exception to policy because she was only a "small amount" over the income limit.

14) The Board of Review cannot make policy exceptions.

APPLICABLE POLICY

WVIMM, Chapter 23, §23.12, provides income tables for the Medicare Premium Subsidies. At §23.12.1, policy addresses Qualified Medicare Beneficiaries (QMB) and requires income under 100% of the Federal Poverty Level (FPL). At §23.12.2, policy addresses Specified Low-Income Medicare Beneficiary (SLIMB) and requires income within the range 101% to 120% of the Federal Poverty Level (FPL). At §23.12.3, policy addresses Qualified Individual (QI) and requires income within the range 121% to 135% of the Federal Poverty Level (FPL) for this Medicaid category.

WVIMM, Chapter 4, Appendix A, shows the following income limits for a household of one (1): QMB - $1305, SLIMB - $1565, and QI-1 - $1761. The same table shows the Medically Needy Income Level (MNIL) for a household of one (1) $200 for one month or $1200 for six months.

WVIMM, Chapter 4, §4.14.4.J, explains that the spenddown amount is dependent on the income amount, and reads:

> To be eligible for Medicaid, the Income Group's (IG) monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are subtracted from the income for the six-month POC, until the income is at, or below, the MNIL for the Needs Group (NG) size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid.

DISCUSSION

The Appellant requested a fair hearing to contest the decision of the Respondent to deny the Appellant's Medicaid application due to excessive income and due to failure to meet a spenddown. The Respondent must show, by preponderance of the evidence, that it correctly denied Medicaid on these bases.

The Appellant applied for Medicaid categories referred to as "buy-in," Medicare Premium Subsidies, or Medicare Premium Assistance (MPA). MPAs are divided into three tiers: QMB, SLIMB, and QI, or QI-1. The monthly income limits for these categories establish overall eligibility as well as the specific tier for which an applicant may qualify. The Appellant exceeds the income limit in all categories.

The Appellant was also considered for Medicaid eligibility through a process and a threshold both referred to as "spenddown." This process involves calculating a "spenddown" amount based entirely on two factors: an applicant's income, and the Medically Needy Income Level, or MNIL.

To become eligible through this process, an applicant must have countable medical bills that exceed the spenddown amount. The Appellant testified that she has medical expenses, but did not specify amounts or claim that she verified bills to meet the $9598.20 spenddown determined in her case.

The Appellant has income from two sources: Social Security income and a pension. The Appellant did not dispute the Respondent's determination of her income from either of these sources, their total, or the resulting spenddown calculation. The Respondent properly notified the Appellant of its determination (Exhibit D-3).

The Appellant explained that she has no dispute of income amounts used by the Respondent but stated that in her opinion she was only over the income limit by a small amount (the exact amount was noted as $104.70 on the Respondent's notice of decision, Exhibit D-3). The Appellant explained that her income does not change her medical situation or medical needs. She testified that she has asthma, type-1 diabetes, contracted COVID and was hospitalized recently. The Board of Review is unable to make policy exceptions, even in instances where medical needs are clear.

Because the Appellant did not have a dispute of fact, the Respondent's denial of Medicaid – both for MPAs and through a spenddown – is affirmed.

CONCLUSIONS OF LAW

1) Because the Respondent denied the Appellant for Medicaid based on a determination of her income, and a spenddown amount is dependent entirely on her income, any dispute of fact in this matter must include a dispute of income.

2) Because the Appellant did not dispute her income, she did not have a dispute of fact.

3) The Board of Review cannot create policy, modify policy, or create policy exceptions, regardless of extenuating circumstances.

4) Because there was no dispute of income, the Respondent correctly determined that the Appellant exceeded the income limits for MPA categories of Medicaid and correctly denied Medicaid on that basis.

5) Because there was no dispute of income, the Respondent correctly determined the Appellant's spenddown amount, correctly determined that the Appellant did not meet her spenddown and correctly denied Medicaid on that basis.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the decision of the Respondent to deny the Appellant's application for Medicaid benefits due to excessive income and failure to meet a spenddown.

ENTERED this _____ day of March 2025.

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Todd Thornton
State Hearing Officer