August 26, 2025

[redacted]

RE: [redacted] v. WV DoHS/BFA
ACTION NO.: 25-BOR-2528

Dear Mr. [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,

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

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

cc: Elizabeth Malesick, DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 25-BOR-2528**

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 August 19, 2025.

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

At the hearing, the Respondent appeared by Elizabeth Malesick, Economic Service Worker. The Appellant appeared and was self-represented. Both parties were placed under oath 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 Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant was a recipient of Adult Medicaid for a one-person Assistance Group.

2) On July 21, 2025, the Respondent issued a notice advising the Appellant his Adult Medicaid benefits would end after July 31, 2025, because the Appellant's income exceeded the eligibility limit.

3) The Appellant is employed seasonally at a golf course and submitted June and July 2025 paystubs as verification of his monthly income.

4) The Respondent considered $2,612.25 in gross earned income for the Appellant.

5) Each of the Appellant's June and July 2025 paystubs reflected a "large amount of overtime."

6) At the time of the Respondent's July 21, 2025 decision, the Adult Medicaid income eligibility limit for a one-person AG was $1,735.00.

7) In August 2025, the Appellant's work hours and income began to decrease.

8) The Respondent's worker did not consider an August 2025 reduction in the Appellant's income when determining his July 21, 2025 Adult Medicaid eligibility.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 4.3.2 ***Countable Sources of Income*** provides that for determining Modified Adjusted Gross Income (MAGI) Medicaid Adult Group eligibility, bonuses and awards, wages, salaries, and tip income are countable sources of income.

WVIMM § 1.2.4 ***Client Responsibility*** provides that the client must provide complete and accurate information about his circumstances so that the Worker is able to make a correct determination about his eligibility.

WVIMM § 4.6.1 ***Budgeting Method*** provides that 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 §§ 23.10.4 ***Adult Group*** **and Chapter 4, Appendix A,** ***Income Chart*** provides that 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, 735.

WVIMM §§ 10.6.5.A-B Assistance Group (AG) Closures and § 10.8.1 Change in Income provide that 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 § 9.3.1 *Advance Notice Requirements,* §9.3.1.A. *Adverse Action Requiring Advance Notice,* and § 9.3.1.C *Beginning and Ending of the Advance Notice Period* provides in relevant sections:

When a Medicaid AG is closed, the Respondent must mail advanced notice to the client at least 13 days before the first day of the month in which the benefits are affected. The 13-day advance notice period begins with the date shown on the notification letter. It ends after the 13th calendar day has elapsed.

DISCUSSION

The Respondent determined that the Appellant's income exceeded the Adult Medicaid eligibility limit. The Appellant did not contest the income amount used by the Respondent but argued that his hours began to decrease in August 2025 due to the seasonal nature of working on a golf course.

The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant's income exceeded the $1,735 Adult Medicaid income eligibility limit.

Past income may only be used when it reflects the income the client expects to receive during the certification period. The policy requires the Respondent to consider the income received by the Appellant in the preceding thirty (30) days but permits the Respondent to request income information from a longer period to determine an income amount that the Appellant can reasonably anticipate receiving. According to the policy, the Respondent's worker must determine if the amount is reasonably expected to be the same. During the hearing, the Respondent's worker testified that the Appellant's employer statement was questionable and that a verification checklist was issued requesting proof of income from a longer period. According to the Respondent worker's testimony, the Appellant complied with the request and submitted paystubs for June and July 2025.

During the hearing, the Respondent's representative testified regarding the amount of income used to determine the Appellant's eligibility. The Respondent's representative testified that the Appellant's paystubs consistently reflected a large amount of overtime income that he could be anticipated to receive in the future. The Respondent considered $2,615.36 gross monthly income for the Appellant based on the submitted June and July 2025 paystubs. The Appellant did not dispute the amount of income used but testified that in August 2025, his income decreased due to a decline in seasonal work hours.

The Appellant was required to provide complete and accurate information about his employment so that the Respondent could calculate the Appellant's monthly income amount and determine his eligibility. Although the Appellant testified during the hearing that his employment was seasonal and his income declined in August 2025, the submitted evidence did not indicate that the Respondent was made aware of the seasonal nature of the Appellant's employment before the July 21, 2025 Adult Medicaid eligibility decision.

Because the information submitted to the Respondent reflected consistent inclusion of overtime income and an impending income decrease was not reported to by the Appellant, the Respondent

correctly determined the Appellant's Adult Medicaid eligibility based on the information supplied by the Appellant. As the Appellant's income did not decrease until after the Respondent's Adult Medicaid eligibility decision, the reduction of the Appellant's income could not be considered by the Respondent when determining his July 21, 2025 Adult Medicaid eligibility.

As the Responded acted in accordance with policy by considering the information submitted by the Appellant when determining his Adult Medicaid eligibility in July 2025, the Respondent's decision to terminate the Appellant's Adult Medicaid eligibility after July 2025 because his income exceeded the Medicaid eligibility limit is affirmed.

During the hearing, the Respondent's worker instructed the Appellant to re-apply for Adult Medicaid eligibility based on reduced income but would need to supply new income verification with his application.

CONCLUSIONS OF LAW

1) To be eligible for Adult Medicaid benefits, the Appellant's income could not exceed $1,735 for a one-person Assistance Group (AG).

2) The client must provide complete and accurate information about his circumstances so that the Worker is able to make a correct determination about his eligibility.

3) The preponderance of evidence revealed that the Appellant did not inform the Respondent of his impending income reduction when he verified his gross monthly income amount.

4) The Respondent correctly used the paystubs submitted by the Appellant when determining his Adult Medicaid eligibility.

5) The preponderance of evidence revealed that the Appellant's $2,615.26 gross monthly income exceeded the Adult Medicaid eligibility limit.

6) Because the Appellant's income exceeded the Adult Medicaid eligibility limit, the Respondent's decision to terminate his Adult Medicaid eligibility was correct.

7) When a Medicaid AG is closed, the Respondent must mail advanced notice to the client at least 13 days before the first day of the month that benefits are affected.

8) The preponderance of evidence revealed that the Respondent did not provide the Appellant with sufficient advanced notice before terminating his Adult Medicaid eligibility.

9) Because the Respondent did not provide the Appellant with sufficient notice before terminating his Adult Medicaid benefits, the Respondent incorrectly terminated his Adult Medicaid benefit eligibility after July 31, 2025. Therefore, his benefits must be retroactively reinstated until proper notice is issued.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Adult Medicaid eligibility after Jul 31, 2025.

ENTERED this 26th day of August 2025.

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Tara B. Thompson, MLS
Certified State Hearing Officer