October 17, 2025

[redacted]

RE: [redacted] v. WV DoHS/BFA
ACTION NO.: 25-BOR-2840

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 (DoHS). 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: Eben McClung, Amanda Williamson, Julie Villers — [redacted] County DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-2840**

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 October 1, 2025.

The matter before the Hearing Officer arises from the Respondent's June 16, 2025 decision to terminate the Appellant's Medicaid eligibility.

At the hearing, the Respondent appeared by Julie Villers, DoHS. The Appellant appeared and was self-represented. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:
D-1 DFA-SLA-1 Application form, received on April 14, 2025
D-2 Appellant's 2023 1040 U.S. Individual Income Tax Return Form
D-3 Email correspondence
D-4 DoHS Notice, issued on June 16, 2025
D-5 Case Comments
D-6 West Virginia Income Maintenance Manual (WVIMM) excerpts
D-7 Verification Checklist, issued on May 28, 2025
Hearing Request Summary

Appellant's Exhibits:
A-1 Hearing Request Form
June 16, 2025 notice excerpt
Appellant Statement

Screen print
Appellant's 2023 1040 U.S. Individual Income Tax Return Form
Who is Eligible for Medicaid screen print
Form 4868 Application for Automatic Extension of Time to File U.S. Individual Tax Return

A-2 [redacted] Paystubs, check date September 26, 2025

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 resides in a household with his spouse, [redacted] and their two juvenile children (Exhibits D-1 and D-2).

2) On June 16, 2025, the Respondent issued a notice advising the Appellant his Medicaid Parent/Caretaker benefits would stop after June 30, 2025, because he did not turn in all requested information.

3) On June 16, 2025, the Respondent issued a notice advising the Appellant the Medicaid Adult Group eligibility for [redacted] was denied. The basis for termination was because the Appellant did not turn in all requested information and does not meet eligibility requirements for Medicaid assistance (Exhibit D-4).

4) The *Statement Calculation* included on the notices revealed $1,445.12 earned income and $1,633 unearned income were used to determine Medicaid eligibility on June 16, 2025 (Exhibit D-4).

5) On April 14, 2025, the Respondent received the Appellant's DFA-SLA-1 application form (Exhibit D-1).

6) The Appellant indicated that his juvenile children were recipients of Medicaid (Exhibit D-1).

7) The Appellant requested three-months backdated Medicaid coverage for himself and [redacted] (Exhibit D-1).

8) Under Step 2, Item 20 *Other Income This Month*; Item 32 *Deductions*; and Item 33 *Yearly Income* for himself and [redacted] the Appellant handwrote, "Please Refer to Attached Tax Return" (Exhibit D-1).

9) Under Step 2, *Current Job*, the Appellant indicated [redacted] worked 21 hours weekly, beginning in April 2021, and received wages weekly (Exhibit D-1).

10) On the application, the Appellant marked on Item 8 of the *Rights and Responsibilities* that he understood that any information given is subject to verification by an authorized representative of the Respondent (Exhibit D-1).

11) On May 19, 2025, the Respondent's Worker [redacted] processed the Appellant's Medicaid application and verified the household's unearned income "using SOLQ" and "Used CS as best available info for earned income" (Exhibit D-5).

12) On May 19, 2025, the Respondent decided that the Appellant and children were eligible for Medicaid benefits but denied [redacted] based on her income.

13) The Respondent did not mail a written notification providing the Appellant with the final decision on his application and basis for the decision.

14) On May 28, 2025, the Appellant reported via telephone that the income used to calculate the household's MAGI amount was incorrect. The Respondent's worker recorded: "Requested PS in POC Sat Apr 19, 2025 — Sun May 18, 2025 PS dated 5/16/2025, 5/9/2025, 5/2/2025, 4/25/2025" (Exhibit D-5).

15) On May 28, 2025, the Respondent issued a verification checklist requesting that "Proof of gross earned income, such as paystubs/employer statement/ [redacted] [sic]; 04-25-2025; 05-02-2025; 05-09-2025; 05-16-2025," be returned by June 7, 2025. The notice instructed that if verification is not received by the deadline, benefits may be denied or closed (Exhibits D-5 and D-7).

16) The *Verification Checklist* instructed the household to contact the office right away if the household had questions or problems getting the verification documents (Exhibit D-7).

17) On June 16, 2025, the Respondent issued notices advising the Appellant his Medicaid benefits were terminated, and [redacted] was denied Medicaid eligibility because requested verification was not returned (Exhibit D-5).

APPLICABLE POLICY

WVIMM § 1.2.2.A *Application Process* This process determines initial eligibility for one or a combination of programs… The application may be held, pending receipt of necessary information or verification, but there are processing time limits that must be met. All applications must have a final disposition, and the client must be notified of the decision.

WVIMM § 1.2.7 *Client Notification* provides that the client must be notified in writing of the final decision on his application and the reason for it. Notification must be provided for each Program for which the client applied, but notification for more than one program may be included on one form letter. Under some circumstances, the eligibility system automatically generates notification to the client.

During the intake interview or during some other client contact prior to written client notification, the Worker may know whether the client is eligible. The Worker may tell the client the status of his application and/or benefit level. However, even if the client has been told his status and/or benefit level, he must still receive the information in writing.

WVIMM § 4.7 The Modified Adjusted Gross Income (MAGI) methodology is used to determine financial eligibility for the following Medicaid eligibility groups including Parents and Other Caretaker Relatives; Children Under 19; and the Adult Group. **WVIMM § 4.7.1** ***Determining Income Counted for the MAGI Household*** provides that the 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.

WVIMM § 3.5 ***Medicaid- General Eligibility*** provides that the Medicaid assistance group (AG) is composed of the individuals who meet the eligibility requirements for coverage under a specific Medicaid coverage group. However, the income of the AG does not determine financial eligibility for all coverage groups. Some coverage groups require the determination of an income group (IG) to determine countable income and a needs group (NG) for comparison to the appropriate needs standard to determine financial eligibility. The case in which the AG members receive coverage may be composed of eligible AG members of one or more coverage groups.

WVIMM § 23.10.2 ***Children Under Age 19*** provides Medicaid coverage when all the following conditions are met: The child is not eligible for SSI Medicaid; the child is under age 19; and, the income eligibility requirements described in Chapter 4 are met. For two children, income had to be equal to or less than 141% FPL.

WVIMM § 3.6 ***Children Under Age 19 Medicaid – Assistance Group*** Stipulates that only the child under age 19 is included. **WVIMM § 3.6.2** ***Children Under Age 19 Medicaid – The Modified Adjusted Gross Income (MAGI) Household Income Group (IG) and Needs Group (NG)*** provides that the methodology for determining the MAGI household's IG and NG is the same as found in section 3.7.

WVIMM § 23.10.1 ***Parents/Caretaker Relatives*** Medicaid group provides coverage when the parent is living in the household with the dependent child for whom he assumes primary responsibility and the income eligibility requirements in Chapter 4 are met. To be eligible, income must be within the Parent/Caretaker Relative Medicaid Limit.

WVIMM § 3.10.1 ***Parents/Caretaker Relatives Group – The Assistance Group*** provides that only the parent and the spouse who lives with him can be included. **WVIMM § 3.10.2** ***The MAGI Household Income Group (IG) and Needs Group (NG)*** provides that the methodology for determining the MAGI household's IG and NG is the same as found in section 3.7.

WVIMM § 23.10.4 ***Adult Group*** provides Medicaid coverage to individuals who meet the following requirements:

- Are age 19 or older and under age 65;

- Are not eligible for another categorically eligible Medicaid coverage group: SSI, Deemed SSI, Parents/Caretaker Relatives; Pregnant Women; Children Under Age 19; Former Foster Children;
- Are not entitled to or enrolled in Medicare Part A or B; and
- The income eligibility requirements described in Chapter 4 are met.
- Parents living with a dependent child under the age of 19 are not eligible for Medicaid in the Adult Group unless the child is receiving benefits under Medicaid, WVCHIP, or otherwise enrolled in minimum essential health coverage (MEC).

Eligibility for this group is determined by using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7 and must be equal to or less than 133% FPL.

WVIMM § 3.7.1.A ***Adult Group – Assistance Group*** provides that Adults age 19 or older and under age 65 must be included. **WVIMM § 3.7.1.B** provides that individuals eligible for Children Under Age 19 and Parents/ Caretakers coverage cannot be included in the AG.

WVIMM § 3.7.2 ***The MAGI Household Income Group*** provides that the 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 is not counted.

WVIMM § 3.7.3 ***The MAGI Household Needs Group (NG)*** provides that married couples who reside together must be included in the MAGI household of the other spouse. If the applicant is a child under 19 who is claimed as a tax dependent, the applicant's Medicaid household consists of the applicant, the tax filers claiming him as a dependent, and any other dependent in the tax filer's household. This is known as the tax dependent rule.

WVIMM § 4.3.2 Chart 2 provides that MAGI coverage groups include Adult Group, Children Under Age 19, and Parent/ Caretaker Relatives. Countable sources of income for determining MAGI coverage group eligibility include Social Security Benefits, Wages, and Salaries.

WVIMM § 4.6.1 ***Budgeting Method*** provides 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. 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. **WVIMM § 4.6.1.A** instructs that past income is used when income from the source is expected to continue into the certification period or POC and 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 from the same employer, not just the continued receipt of earned income.

WVIMM § 4.6.1.B ***Consideration of Past Income*** provides that the Worker must determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days before the application. The appropriate time period is determined by counting back 30 days beginning with the calendar day before the date of application. When, in the Worker's judgement, future income may be more reasonably anticipated by considering the income from a longer period of

time, the Worker considers income for the period he determines to be reasonable. Whether the Worker considers income from the prior 30 days, or from a long period of time, all 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.

The Worker must record the results, including the amount of income, and why the source is or is not being considered for the new certification period, 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.

WVIMM § 7.2.5.B *Reasonable Compatibility* provides that Medicaid eligibility determinations will be based on, to the maximum extent possible, on the applicant self-attestation verified by information obtained from electronic data sources. When income and asset information obtained through electronic data sources is reasonably compatible with an applicant's attestation, the self-attested information is considered verified.

Self-attestation information and information from the data source are reasonably compatible when any difference or discrepancy between the two sources does not impact the eligibility of the application. If income and asset information obtained through electronic data sources is not reasonably compatible with an applicant's attestation, additional documentation may be required.

WVIMM § 7.2.5.C *Applying Reasonable Explanation* provides that the Worker must reconcile discrepancies in self-attestation and information provided by FDH using a process that includes the following steps:

- The Worker must give the applicant the chance to provide an explanation for the differences. If the client explains the differences and the Worker accepts the explanation as reasonable, no further verification is necessary. The Worker can use the self-attested information.
- If the applicant's explanation is questionable and the Worker does not accept it as reasonable, the Worker must check all other electronic databases first, as well as any other information available to the Department, such as the client record, before requesting verifications from the applicant.
- If, after checking other available sources and requesting and reviewing verification from the applicant, the Worker cannot reconcile the self-attested information with information received from an electronic data source as reasonably compatible, then additional information is requested.

WVIMM § 6.1 *Data Exchanges* and *Federal Data Hub* provides that the Federal Data Hub (FDH) and the Income and Eligibility Verification System (IEVS) provide electronic verifications to the Department. The Department's Worker evaluates for Medicaid eligibility by testing for Modified Adjusted Gross Income (MAGI) coverage groups first, which requires a check of results primarily from the FDH. Data exchange information available at application and review may also be used by the Worker to evaluate discrepancies in the client's statement when it disagrees with the Hub data.

When no information is returned from the HUB or when discrepancies exist that are not reasonably compatible, the Worker must utilize all sources available before requesting verification from the client.

WVIMM § 6.3 ***Federal Data Exchanges*** include the Internal Revenue Service (IRS), Prisoner Match, the Beneficiary and Earnings Data Exchange (BENDEX), and the Beneficiary Earnings Exchange Record System (BEERS)…. For individuals applying for MAGI Medicaid, the primary data source used by the Worker is the Hub. When the Hub returns no information or when discrepancies exist between an individual's self-attestation and the Hub information, the Worker seeks information from other electronic sources, including those listed in the following sections

6.3.2 *Internal Revenue Service (IRS)* provides that the IRS may provide individual tax information for use in determining eligibility for MAGI Medicaid through the FDH.

6.3.4 *Social Security Administration (SSA)* provides that through FDH, the SSN is considered verified for MAGI Medicaid. Other information received from the Hub may include receipt of Social Security income; pensions; earnings; Retirement, Survivors and Disability Insurance (RSDI); Supplemental Security Income (SSI); and other related benefit information received through SSA.

6.3.4.A *Beneficiary and Earnings Data Exchange (BENDEX)* data exchange occurs daily. Information received includes RSDI amounts and Medicare eligibility premiums.

6.3.4.A.2 *Beneficiary Earnings and Exchange Records System (BEERS)* wage-match data exchanges occur daily. Information received includes wages; pensions; and self-employment income.

6.3.4.B *Worker Requested Verification – State On-Line Query (SOLQ)* provides direct access to SSA's databases. The Worker must initially use the HUB for evaluating eligibility for MAGI Medicaid, IEVS data exchange for all other programs, and SOLQ last. Information received includes SSN verification, as well as SSI and RSDI details.

DISCUSSION

The Appellant applied for Medicaid coverage for a four-person household. On May 19, 2025, the Respondent denied Medicaid coverage for [redacted] because her income exceeded the eligibility limit. During the hearing, the Appellant contested the Respondent's use of income to determine the MAGI amount when deciding the AG's eligibility on May 19, 2025. As the June 2025 Medicaid termination was after the May 2025 denial, and the Respondent failed to issue a written notice to the Appellant, it must be determined whether the Respondent accurately calculated the MAGI when deciding the AG's May 2025 Medicaid eligibility.

While the policy permits the Respondent to tell the client the status of his application, the policy requires the Respondent to notify the client in writing of the final decision on his application and the reason for the decision. Notification must be provided for each program applied for.

Even though a case comment reflected that [redacted] was denied eligibility in May 2025, the preponderance of evidence demonstrated that the Respondent failed to issue a notice to the household advising the Appellant of the final decision on his April 2025 application.

Although the household was initially prejudiced by being delayed the right to contest the May 2025 decision, no further relief is available on the issue of *Notice* because the Appellant was afforded an opportunity to contest the Respondent's May 2025 eligibility decision during the instant hearing.

To prove that the Respondent correctly decided the household's Medicaid eligibility in May 2025, the evidence had to demonstrate that the AG's May 2025 income exceeded the eligibility limit.

Who is included in the Income Group (IG) and Needs Group (NG):
While the policies vary regarding who can be included in the AG for each Medicaid category, the policies for Children Under Age 19 Medicaid, Parents/Caretaker Relatives Group, and Adult Group share the methodology for determining the MAGI household's IG and NG. According to the policy, each member of the Appellant's four-person household must be included in the same NG. Pursuant to the policy, each member's income is counted when determining the household's MAGI amount.

During the hearing, the Respondent's representative testified that the children's income was excluded. According to the policy, the Respondent correctly excluded the income of juveniles residing in the Appellant's household. Pursuant to the policy, the income of the Appellant and his spouse must be considered when determining the household's MAGI amount.

Eligibility Income Limits
The policy provides that to be eligible for parent/caretaker relatives, income must be within the Parent/Caretaker Relative Medicaid limit. To be eligible for Children Under Age 19 Medicaid for an assistance group with two qualifying children, income must be equal to or less than 141% of the FPL. According to the policy for Adult Group Medicaid, income must be equal to or less than 133% of the FPL to establish eligibility.

Consideration of Income
The policy requires that income received in the 30 days before application be considered when deciding the AG's Medicaid eligibility. According to the policy, the Respondent may look at a longer period, but all income received from that source during the period must be considered and be consecutive. The policy also requires the Respondent to record the amount of income, the time period used, and include the reason additional income was considered beyond the previous 30 days. For Medicaid, earned and unearned income must be verified before initial approval, at application, at redetermination, and when a change in the amount is reported. The policy instructs the Respondent's worker to use the best source of verification available.

During the hearing, the Respondent's representative testified that she personally processed the Appellant's application on May 19, 2025. According to the case comments, the Respondent's decision on May 19, 2025, was based on the Appellant's statement regarding household income.

According to the policy, sources of verification of earned income include paystubs, written employer statements, or work record sheet DFA-17. Possible sources of verification for unearned income include award letters; computer matches; written statement from source; and eligibility system data exchanges, including the Federal Data Hub (FDH).

When there is absolutely no other source of verification, the policy instructs that the client's statement must be used. WVIMM 7.2.3 provides that client self-attestation is verified by electronic data sources. According to the policy, the Respondent utilizes the FDH to verify reported information for MAGI Medicaid. For Medicaid, the client must not be required to provide verification unless information cannot be obtained electronically or self-attestation, and electronic data sources are not reasonably compatible. If the income information obtained through electronic data sources is not reasonably compatible with the client's attestation, additional documentation may be required.

If a discrepancy is discovered, the Respondent must provide the client with an opportunity to explain the difference. If, after checking other available sources and requesting and reviewing information from the applicant, the Worker cannot reconcile self-attested information with information provided by an electronic data source as reasonably compatible, then additional information is requested.

When he applied, the Appellant provided his 2023 tax statement to verify the household's income. While the policy permits the Respondent to utilize the FDH to verify income information provided by the IRS, the tax information provided by the Appellant was from the 2023 income year. Although the Appellant successfully argued that the provided 2023 tax forms are the most recent filings required by law, the information reflected on the forms does not satisfy the policy requirement to establish a monthly amount of income by examining the AG's income received in the 30-calendar days before the application.

The Respondent testified that the amount of income reflected on the tax return was discrepant with the information in the FDH. Pursuant to the submitted evidence, the Respondent did not request income verification or provide the client with an opportunity to explain the discrepancy. The submitted evidence did not indicate that the Respondent flagged a difference between the client's statement and the information provided by the data exchange or explain why income verification was not requested from the Appellant at this juncture.

During the hearing, the Respondent was given an opportunity to explain the Respondent's process of income consideration when determining the AG's May 2025 eligibility. The Respondent's representative testified the Appellant's unearned income was verified via SOLQ. During the hearing, the Respondent's representative was unsure of which type of unearned income the Appellant was receiving. The Appellant testified that he was receiving, "regular social security."

According to the testimony provided by the Respondent's representative, she used paystubs provided by [redacted] in October 2024 to determine eligibility because the tax information provided by [redacted] was outdated. The Respondent's representative testified that in May 2025, the amount of income earned reflected on the October 2024 paystubs, was consistent with the information provided by the FDH and exceeded the income eligibility limit. While the Respondent

was permitted to include a longer period of income, the evidence failed to demonstrate that the income considered was comprised of all income received from that source during the period and was consecutive.

During the hearing, the Respondent's representative testified that the household's income was calculated using a bi-weekly earned income amount for [redacted] however, the Appellant indicated on his application that [redacted] was paid weekly. The October 2024 paystubs relied upon by the Respondent were not submitted as documentary evidence. Further, evidence was not submitted to clarify how the household's income was compared to the income limits for each Medicaid category when the Respondent evaluated the AG for eligibility in May 2025.

When reviewing the Appellant's eligibility for deductions, the Respondent's worker was not sure whether a 5% disregard was applied when determining the household's May 2025 income eligibility. The Respondent's witness testified that a 20% earned income disregard was applied. When reviewing the amount of income reflected on the June 2025 notice, the Respondent's representative testified that the income on the notice included the application of a 20% earned income disregard. Although evidence was submitted regarding the proposed amount of income for the household on June 16, 2025, the submitted evidence did not demonstrate what amount of combined earned and unearned income was considered by the Respondent when determining the household's Medicaid eligibility on May 19, 2025.

The Respondent is required to keep sufficient records of eligibility decisions so that a reviewer may understand how the Respondent determines eligibility. Although the Respondent testified regarding her use of October 2024 income, the submitted record did not reveal the amount of income, period used, or reason additional income was considered.

The preponderance of evidence failed to prove that [redacted] income exceeded the Medicaid eligibility limit in May 2025. Because a verified amount of the Appellant's household income for the thirty days before his application was not established by the submitted evidence, the Respondent's May 2025 decision on the Appellant's April 2025 application must be reversed and remanded for issuance of an income verification request and a new assessment of eligibility.

June 2025 Decision

Because the matter is remanded for verification and a new determination of eligibility from the Appellant's application date, the issue of failure to verify income in June 2025 is moot and the subsequent June 2025 adverse action cannot be affirmed.

CONCLUSIONS OF LAW

1) For Medicaid, earned and unearned income must be verified before initial approval, at application, at redetermination, and when a change in the amount is reported.

2) The preponderance of evidence failed to establish an amount of income for the Appellant's household at the time of his April 2025 application.

3) Because a monthly amount of income was not verified for the thirty days before the Appellant's application, the matter must be remanded for issuance of an income verification request and a new determination regarding the household's eligibility from the application date.

4) Because the matter is remanded for verification and redetermination of eligibility from the Appellant's application date, the issue of the Appellant's failure to verify income in June 2025 is moot and the subsequent June 2025 adverse action cannot be affirmed.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's Medicaid eligibility denial made on May 19, 2025, and June 16, 2025. The matter is **REMANDED** for issuance of an income verification request and new determination regarding the household's eligibility from the date of application.

ENTERED this 17th day of October 2025.

_____

Tara B. Thompson, MLS
Certified State Hearing Officer