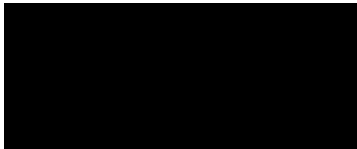




April 29, 2026



RE: [REDACTED] v. WV DoHS/BFA  
ACTION NO.: 26-BOR-1663

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: Elizabeth Malesick, DoHS

**WEST VIRGINIA OFFICE OF INSPECTOR GENERAL  
BOARD OF REVIEW**

[REDACTED]  
**Appellant,**

v.

**Action Number: 26-BOR-1663**

**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] Sr. 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 April 15, 2026.

The matter before the Hearing Officer arises from the Respondent's decision on March 20, 2026, to terminate the Appellant's Adult Medicaid eligibility.

At the hearing, the Respondent appeared by Elizabeth Malesick. The Appellant appeared and was self-represented. All witnesses 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 is a recipient of Adult Medicaid for a one-person Assistance Group (AG).
- 2) On March 20, 2026, the Respondent issued a notice advising the Appellant his eligibility for Adult Medicaid would end after March 31, 2026, because his income exceeded the eligibility limit.
- 3) The notice reflected \$2,144 unearned monthly income for the Appellant and compared that income to a \$1,769 Adult Medicaid monthly income eligibility limit.
- 4) The Appellant receives \$2,144 gross monthly Retirement, Survivors, and Disability Insurance (RSDI), and \$793.60 gross monthly Black Lung benefits.
- 5) The Respondent evaluated the Appellant and determined that he was financially eligible for the Aged and Disabled Waiver (ADW) program.

## **APPLICABLE POLICY**

**West Virginia Income Maintenance Manual (WVIMM) § 4.3.2 Chart 2** provides that for Adult Group Medicaid, social security benefits are countable sources of income. Black Lung benefits are excluded income.

**WVIMM Chapter 4, Appendix A Income Limits** provides that for a one-person AG, 133% of the Federal Poverty Level (FPL) is \$1,735.

**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 § 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 §§ 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 13<sup>th</sup> calendar day has elapsed.

### **DISCUSSION**

The Respondent determined the Appellant's income exceeded the Adult Medicaid eligibility limit. During the hearing, the Appellant did not contest the income amount considered by the Respondent but requested that his Adult Medicaid benefits be extended until completion of his medical evaluation for the Aged and Disabled Waiver (ADW) program.

According to the policy, an AG may be closed when the client's income exceeds the eligibility limit. To prove that the Respondent correctly terminated the Appellant's Adult Medicaid eligibility, the Respondent had to demonstrate by a preponderance of evidence that the Appellant's income exceeded the \$1,735 Adult Medicaid eligibility limit.

Pursuant to the policy, RSDI income must be considered when determining Adult Medicaid eligibility; however, the policy instructs that Black Lung benefits must be excluded. During the hearing, the Appellant did not dispute receiving \$2,144 gross monthly RSDI. The preponderance of submitted evidence proved that the Appellant's \$2,144 gross monthly RSDI exceeded the \$1,735 Adult Medicaid eligibility limit.

The policy requires the Respondent to consider the Appellant's eligibility for other coverage groups before notifying him that his Adult Medicaid eligibility will end. During the hearing, testimony was provided that established that the Respondent considered the Appellant's eligibility for other Medicaid coverage groups and found that the Appellant was financially eligible for the ADW program. The Appellant affirmed that he is scheduled to be medically evaluated on May 20, 2026, for the ADW program. Pursuant to the evidence, the Respondent evaluated the Appellant for other Medicaid coverage groups as required before notifying him of his Adult Medicaid termination.

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 benefits are affected. To prove that the Respondent correctly terminated the Appellant's Adult Medicaid effective April 1, 2026, the evidence had to

demonstrate that sufficient advanced notice was mailed to the Appellant. Pursuant to the March 20, 2026 notice, the Respondent did not provide the Appellant with 13 days advanced notice before the proposed date of adverse action. Because the Appellant was not provided with sufficient notification before the proposed date of termination, the matter must be remanded for issuance of timely advanced notification before terminating the Appellant's Adult Medicaid benefits.

### **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 preponderance of evidence revealed that the Appellant's \$2,144 gross RSDI income exceeded the Adult Medicaid eligibility limit for a one-person AG.
- 3) Because the Appellant's income exceeded the Adult Medicaid eligibility limit, the Respondent's decision to terminate his Adult Medicaid eligibility was correct.
- 4) 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.
- 5) The preponderance of evidence revealed that the Respondent did not provide the Appellant with sufficient advanced notice before the proposed date of termination for his Adult Medicaid benefits.
- 6) Because the Respondent did not provide the Appellant with sufficient notice before the proposed termination of his Adult Medicaid benefits, the matter must be remanded for issuance of proper advanced notice before termination of the Appellant's Adult Medicaid eligibility.

### **DECISION**

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to terminate the Appellant's Adult Medicaid eligibility. The matter is **REMANDED** for issuance of sufficient advanced notice of adverse action before ending the Appellant's Adult Medicaid eligibility.

**ENTERED this 28<sup>th</sup> day of April 2026.**

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**Tara B. Thompson, MLS**  
**Certified State Hearing Officer**