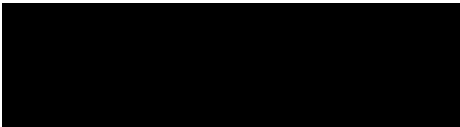




July 28, 2026



RE: [REDACTED] v. WV DoHS/BFA
ACTION NO.: 26-BOR-2173

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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Anna Yoder, WV DoHS/BFA

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

[REDACTED]

Appellant,

v.

Action Number: 26-BOR-2173

**WV 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 July 21, 2026.

The matter before the Hearing Officer arises from the June 4, 2026 decision by the Respondent to deny the Appellant's application for Medicaid benefits.

At the hearing, the Respondent appeared by Anna Yoder, Economic Services Supervisor. The Appellant was self-represented. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Summary
- D-2 Notice of Medicare Premium Assistance, dated June 26, 2026
- D-3 WV Income Maintenance Manual (IMM), Chapter 3, §3.7.1.B

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 receives Medicare benefits.
- 2) On May 14, 2026, the Appellant applied for Medicare Premium Assistance (MPA) benefits.
- 3) On May 21, 2026, the Respondent denied the MPA application and sent notice to the Appellant.
- 4) On May 29, 2026, the Appellant applied for Medicaid benefits, which was denied on June 2, 2026, with the reason stating as not being Aged, Blind, or Disabled.
- 5) On June 3, 2026, the Appellant's application was rerun and a corrected denial letter was issued stating the denial was due to not meeting the spenddown amount of \$12,060.
- 6) The Appellant presented one medical bill in the amount of \$1,241.56, with her request for appeal on June 23, 2026.
- 7) On June 26, 2026, the Appellant was approved for Medicare Premium Assistance (MPA) benefits, specifically, Qualified Individual (QI). (Exhibit D-2)
- 8) The Appellant did not contest the income amount used in determining her MPA approval.
- 9) The Appellant has a special needs trust account which is administered by a Trustee.

APPLICABLE POLICY

WV Income Maintenance Manual (IMM), Chapter 4, §4.12.1, Determining Eligibility, explains that countable income is determined by subtracting any allowable disregards and deductions from the total countable gross income.

Countable income is determined as follows:

Step 1: Determine the total countable gross unearned income and subtract the appropriate disregards and deductions. See Section 4.14.2.

Step 2: Determine the total countable gross earned income and subtract the appropriate disregards and deductions. See Section 4.14.2.

Step 3: Add the results from Step 1 and Step 2 to achieve the total monthly countable income.

Step 4: Compare the amount in Step 3 to the QMB, SLIMB, or QI-1 income levels for the appropriate number of persons. See Section 4.14 for SSI-Related deeming procedures.

If the amount is less than or equal to the QMB, SLIMB, or QI-1 income levels, the client(s) is eligible. Eligibility for these coverage groups is determined as follows:

- QMB – Income is less than or equal to 100% FPL.
- SLIMB – Income is greater than 100% FPL, but less than or equal to 120% FPL.
- QI-1 – Income is greater than 120% FPL, but less than or equal to 135% FPL.

WV IMM, Chapter 1, §1.16.11.B SLIMB and QI-1: SLIMB and QI-1 clients do not receive a Medical ID card. Medicaid coverage is limited to payment of the Medicare, Part B, premium. This is accomplished by the BMS Buy-In Unit.

WV IMM, Chapter 14, SSI-RELATED MEDICAID (Medically Needy, Categorically Need, Optional):

§4.14.1, Budgeting Method, in part:

Some Medically Needy cases may have other considerations, because Medically Needy cases have a fixed Period of Consideration (POC) and the total income for the six-month POC is used to determine the spenddown amount. Therefore, the Worker must take the following steps when the income is expected to change during the POC.

Step 1: Determine the specific months that will constitute the POC.

Step 2: Determine the anticipated earned income for each of the six months, according to Section 4.6.

Step 3: Determine the anticipated unearned income for each of the six months, according to Section 4.6.

Step 4: Take the result from Step 2 and divide by six to determine the average anticipated earned income for the POC.

Step 5: Take the result from Step 3 and divide by six to determine the average anticipated unearned income for the POC.

NOTE: When there is no earned income in a month, use \$0 as income for that month, but always divide by six.

NOTE: When there is no unearned income in a month, use \$0 as income for that month, but always divide by six.

WV IMM, Chapter 23, §23.9, Relationship Between Coverage Groups:

All Medicaid coverage groups are assigned to one of two categories: Categorically Needy and Medically Needy.

- Categorically Needy Medicaid clients are families and children; aged, blind, or disabled individuals; and pregnant women who are eligible to receive Medicaid because they fall into a certain category and meet financial criteria. The federal

government mandates West Virginia to cover some Categorically Needy coverage groups; other coverage groups are optional.

- Medically Needy Medicaid clients are those who would be eligible for Categorically Needy benefits except that their income and/or assets are too high. Even though their resources are too high for Categorically Needy Medicaid eligibility, they have high medical needs and cannot afford to pay their medical bills. These individuals are allowed to “spenddown” their excess income to the Medically Needy Income Level (MNIL) by incurring medical expenses. The spenddown process is explained in Chapter 4.

WV IMM, Chapter 23, §23.11.3, SSI-RELATED (MNIL, Subject to Spenddown):

Individuals who meet the SSI definition of aged, blind or disabled are eligible for Medicaid when all of the following conditions are met. Aged means 65 years or over.

- Countable income is under the Medically Needy Income Limit (MNIL). The income eligibility requirement is detailed in Chapter 4. However, no SSI-Related case is denied due only to excess income. Instead, the Worker must deduct incurred medical bills from countable income for the six-month Period of Consideration. This process is called spenddown and details of this procedure are in Chapter 4. Eligibility and the amount of the spenddown, if any, are determined using the MNIL. The level of the MNIL is determined by each state according to federal guidelines. By law, the MNIL cannot exceed 133% of the State's former AFDC cash assistance payment level, rounded to the nearest \$100, for a family of the same size.

WV IMM, Chapter 1, §1.16.11.B, SLIMB and QI-1: SLIMB and QI-1 clients do not receive a Medical ID card. Medicaid coverage is limited to payment of the Medicare, Part B, premium. This is accomplished by the BMS Buy-In Unit.

DISCUSSION

The Appellant receives Medicare benefits. On May 14, 2026, the Appellant applied for Medicare Premium Assistance (MPA) program benefits but was denied on May 21, 2026. On May 29, 2026, the Appellant applied for Medicaid benefits, which was denied on June 2, 2026, with the reason stating as not being Aged, Blind, or Disabled. On June 4, 2026, a corrected denial notice was issued stating that the Appellant was denied Medicaid due to not meeting the spenddown amount of \$12,060. On June 23, 2026, the Appellant emailed the Respondent’s worker stating that she needed home health care and physical health care at home because she has left-sided paralysis due to a stroke. The Appellant stated in her email that: “The Trust hasn’t helped me out since last August, I sent the email they sent me to you please call me or send me the appeal application ...” A copy of [REDACTED] billing statement was attached to the June 23, 2026 email showing an amount due of \$1,241.56. Subsequently, the Respondent’s worker discovered an error in the May 21, 2026 MPA denial and issued a corrected notice of MPA approval for Qualified Individual MPA coverage on June 26, 2026.

The Appellant brings this appeal stating that she needs Medicaid. The Appellant testified that she had a stroke and has left-sided paralysis. The Appellant testified that she has a special needs trust but the Trustee has not been assisting her with her medical needs. The Appellant stated that she has no transportation to her medical appointments, needs an MRI, and also needs home health. The Appellant had many non-specific complaints about other agency units which were not addressed as they were not within the scope of this hearing.

Policy does allow for Medicaid coverage through the spenddown process under the medically needy category. Although the Respondent's worker incorrectly issued the June 2, 2026 Medicaid denial, a corrected denial was reissued on June 4, 2026, stating that the spenddown amount of \$12,060 was not met. The Appellant did not contest the amount of the spenddown or that the it was unmet. The hearing record shows that she submitted a medical bill to the Respondent in the amount of \$1,241.56.

Additionally, although the Respondent's worker incorrectly denied the Appellant's May 14, 2026 MPA application, it was subsequently corrected and a June 26, 2026 approval of MPA, specifically QI coverage, was issued. The QI benefit only covers the cost of Medicare Premium amounts.

The Respondent showed by a preponderance of evidence that it correctly reissued the notices of June 4, 2026, and June 26, 2026, to the Appellant.

CONCLUSIONS OF LAW

- 1) Policy establishes the income limit for the Medicare Premium Assistance (MPA) categories. Qualified Medicare Benefit (QMB) as 100% of the FPL; Specified Low-Income Medicare Beneficiary (SLIMB) as up to 120% of the FPL; and Qualified Individual (QI) as up to 135% of the FPL.
- 2) The Appellant's monthly countable net income was determined to be \$2,285, which is within the QI coverage limit.
- 3) The Respondent correctly approved the Appellant for QI coverage.
- 4) Policy allows for those eligible under the Medically Needy category to meet a spenddown amount for Medicaid coverage.
- 5) The Appellant failed to meet the spenddown amount for the medically needy category of Medicaid coverage.
- 6) The Respondent correctly denied the Appellant's Medicaid application.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to approve the Appellant's QI MPA benefits and to deny spenddown coverage Medicaid.

ENTERED this 28th day of July 2026.

Lori Woodward, Certified State Hearing Officer