WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 26-BOR-2452**

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 September 1, 2026.

The matter before the Hearing Officer arises from the August 4, 2026 decision by the Respondent to close the Appellant's Medicare Premium Assistance (MPA) benefits, specifically, Qualified Individual (QI) program category.

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 Hearing Summary
- D-2 Notice of QI closure, dated August 4, 2026
- D-3 Desk Guide Income Chart

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 receiving Medicare Premium Assistance (MPA) benefits, specifically under the Qualified Individual (QI) category.

2) On August 3, 2026, the Respondent's worker processed the Appellant's medical review and found that the Appellant's Social Security benefits increased to $1,829 per month in March 2026.

3) The only allowable income deduction or disregard to be applied to the Appellant's income was a $20 unearned income disregard, resulting in a countable net income of $1,809.

4) The income limit for QI eligibility is $1,796 for an individual, or 135% FPL (Federal Poverty Level).

5) On August 4, 2026, the Respondent issued notification to the Appellant that his QI benefits were closing due to being over the allowable income. (Exhibit D-2)

APPLICABLE POLICY

Code of Federal Regulations, PART 407: SUPPLEMENTARY MEDICAL INSURANCE (SMI) ENROLLMENT AND ENTITLEMENT

42 CFR 407.2 General description of program.

407.1 Basis and scope.

(a) ***Statutory basis.*** The supplementary medical insurance (SMI) program is authorized by Part B of title XVIII of the Social Security Act.

(1) Section 1831 of the Act establishes the program.

(2) Sections 1836 and 1837 set forth the eligibility and enrollment requirements.

(3) Section 1838 specifies the entitlement periods, which vary depending on the time and method of enrollment and on the basis for termination.

(4) Section 1843 sets forth the requirements for State buy-in agreements under which States may enroll, and pay the SMI premiums for, eligible individuals who are also eligible for cash assistance or Medicaid.

(5) Section 104(b) of the Social Security Amendments of 1965 (Pub. L. 89-87) specifies the limitations that apply to certain aliens and persons convicted of subversive activities.

(6) Sections 1836(b) and 1837(n) of the Act provide for coverage of immunosuppressive drugs as described in section 1861(s)(2)(J) of the Act under Part B beginning on or after January 1, 2023, for eligible individuals whose benefits under Medicare Part A and eligibility to enroll in Part B on the basis of ESRD would otherwise end with the 36th month after the month in which the individual receives a kidney transplant by reason of section 226A(b)(2) of the Act.

(b) ***Scope.*** This part sets forth the eligibility, enrollment, and entitlement requirements and procedures for the following:
(1) Supplementary medical insurance. (The rules about premiums are in part 408 of this chapter.)
(2) The immunosuppressive drug benefit provided for under sections 1836(b) and 1837(n) of the Act, hereinafter referred to as the Part B-Immunosuppressive Drug Benefit (Part B-ID).

42 CFR 407.40(b): Buy-in group means a coverage group described in section 1843 of the Act **that is identified by the State and is composed of multiple Medicaid eligibility groups specified in the buy-in agreement**. [Emphasis added]

Code of Federal Regulations, 42 CFR Part 408: **PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE**

42 CFR 408.1(a), This part implements certain provisions of sections 1837 through 1840 and 1881(d) of the Social Security Act (the Act) and conforms to other regulations that implement section 1843 of the Act. Section 1838(b) requires regulations to establish when an individual's coverage ends because of nonpayment of premiums. It also specifies that those regulations may provide a grace period for payment of overdue premiums without loss of coverage. Section 1839 sets forth the specific procedures for determining the amount of the monthly premium and section 1840 establishes the rules for payment of premiums. **Section 1843 provides that a State may enter into a buy-in agreement to secure SMI coverage for certain individuals by enrolling them in the SMI program and paying the premiums on their behalf.** Section 1881(d) provides that Medicare payment, for the reasonable charges incurred in connection with a kidney donation, shall be made (without regard to deductible, premium, or coinsurance provisions of title XVIII) as prescribed in regulations. [Emphasis added]

42 CFR 408.6(c), Payment by a State under a buy-in agreement, in part:
(1) A buy-in agreement is an agreement under which a State, through enrollment and payment of SMI premiums, secures SMI benefits for individuals who are eligible for that program and also eligible for certain other cash or medical benefits. (Policies on enrollment under State buy-in agreements are contained in subpart C of part 407 of this chapter.)
(2) The State pays the premiums for each month for which an individual is covered under the agreement.

§435.123 Individuals eligible as qualified Medicare beneficiaries.
(a) Basis. This section implements sections 1902(a)(10)(E)(i) and 1905(p)(1) of the Act.
(b) Eligibility. The agency must provide medical assistance to individuals who meet all of the following:
(1) Are entitled to Medicare Part A based on the eligibility requirements set forth in § 406.5(a) or § 406.20(b) of this chapter or who are enrolled in Medicare Part B for coverage of immunosuppressive drugs based on eligibility requirements described in § 407.55 of this chapter.

(2) Have an income, subject to paragraphs (b)(2)(i) and (ii) of this section, that does not exceed 100 percent of the Federal poverty level.
(i) During a transition month (as defined in paragraph (b)(2)(ii) of this section), any income attributable to a cost of living adjustment in Social Security retirement, survivors, or disability benefits does not count in determining an individual's income.
(ii) A transition month is any month of the year beginning when the cost of living adjustment takes effect, through the month following the month of publication of the revised official poverty level.
(3) Have resources, determined using financial methodologies no more restrictive than SSI, that do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the Consumer Price Index for inflation as defined in section 1905(p)(1)(C) of the Act.
(c) Scope. Medical assistance included in paragraph (b) of this section includes all of the following:
(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for Parts A and B premiums and cost sharing, including deductibles and coinsurance, and copays.
(2) For individuals enrolled in Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

42 CFR 435.601(e), ***Procedures for determining eligibility for the Medicare Savings Program groups.*** When a State determines eligibility for a Medicare Savings Program group, for income eligibility the agency must include at least the individuals described in §423.772 of this chapter in determining family of the size involved.

42 CFR 435.602(b), Requirements for States using more restrictive requirements. Subject to the provisions of paragraph (c) of this section, in determining financial eligibility of aged, blind, or disabled individuals in States that apply eligibility requirements more restrictive than those used under SSI, the agency must apply:
(1) The requirements and methodologies for financial responsibility of relatives used under the SSI program; or
(2) More extensive requirements for relative responsibility than specified in § 435.602(a) but no more extensive than the requirements under the Medicaid plan in effect on January 1, 1972

42 CFR 435.603(j)
Eligibility Groups for which MAGI-based methods do not apply. The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in § 435.601 and § 435.602 of this subpart.

Code of Federal Regulations, 42 CFR, §435.125, Individuals Eligible as Qualifying Individual:

(a) ***Basis.*** This section implements sections 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) of the Act.
(b) ***Eligibility.*** The agency must provide medical assistance to individuals who meet the eligibility requirements in § 435.123(b), except that income is at least 120 percent, but is less than 135 percent of the Federal poverty level.
(c) ***Scope.*** Medical assistance included in paragraph (b) of this section includes the following:
(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for the Part B premium.
(2) For individuals enrolled under Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only payment of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

42 CFR 435.603(j)(5)
Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

WV Income Maintenance Manual (IMM), Chapter 4, §4.12.1, Determining Eligibility, explains that *c*ountable 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 4, §4.14.2.B Unearned Income

§4.14.2.B.1 SSI $20 Disregard

A $20 disregard is applied to the total gross unearned income. If unearned income is less than $20, the remainder is subtracted from earned income, prior to the application of any other earned income disregards and deductions.

NOTE: The SSI $20 disregard is not applied to any unearned income received that is based on need. This includes, but is not limited to, Veterans Affairs (VA) benefits based on need. See VA Benefits in Section 4.3.

WV IMM, Chapter 23, §23.12.3, Qualified Individual (QI), explains that the income limit is 121 –135% FPL, and assets must not exceed $9,950 for individuals and $14,910 for couples. Medicaid coverage is limited to payment of the Medicare Part B premium. An individual or couple (spouses) is eligible for limited* Medicaid coverage when all the following conditions are met:

- The individual must be enrolled in Medicare, Part A. He must be entitled in any of the following three ways:
  - By being age 64 years and 9 months old or older;
  - By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,
  - By having end-stage renal disease;
- The individual or couple must meet the income test detailed in Chapter 4;
- The individual or couple must meet the asset test detailed in Chapter 5; and
- The individual or couple is not eligible for any full-coverage Medicaid group

Medicaid coverage is limited to payment of the Medicare Part B premium. The Buy-In Unit pays the Medicare premium. Refer to Chapter 25 for details.

DISCUSSION

The Appellant was receiving Qualified Individual (QI), the highest income category available for the MPA program. The Appellant underwent a review for continued MPA benefits in July 2026. On August 3, 2026, the Respondent's worker processed the Appellant's medical review and found that the Appellant's Social Security benefits increased to $1,829 per month in March 2026. After applying the only allowable income deduction or disregard available to the Appellant of a $20 unearned income disregard, the Respondent determined he had a countable net income of $1,809. Because the income limit for QI eligibility is $1,796 for an individual, the Respondent issued a closure notice to the Appellant on August 4, 2026, explaining that he exceeded the income limit for program eligibility.

The Appellant appeals the Respondent's decision stating that he believes that a $20 disregard should have been not only used in the calculation of his income but also to reduce the income limit established by state and federal regulations.

Under 42 U.S.C. §1395v (Section 1843 of the Social Security Act) states are authorized to enter into "Buy-In" agreements with the Centers for Medicare & Medicaid Services (CMS) to pay Medicare Part B premiums for eligible individuals. West Virginia is a buy-in state. Under the State's authority and through its State Plan Agreement, the Department of Human Services determines the eligibility for its Medicare Premium Assistance (MPA) Programs, specifically, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLIMB), and Qualified Individual (QI) categories. The income limits used are those established by the federal government. The Respondent under its buy-in agreement with the

federal government incorporates the basis of determining program eligibility in its Income Maintenance Manual (IMM). The established income limits for the Medicare Premium Assistance (MPA) categories are: Qualified Medicare Benefit (QMB) as 100% of the FPL; Specified Low-Income Medicare Beneficiary (SLIMB) as up to 120% of the FPL; and Qualifying Individuals (QI-1) as up to 135% of the FPL, or $1,796.

The Respondent's representative, Anna Yoder, testified that a $20 disregard was used in calculating the Appellant's countable income for program eligibility as mandated by policy. However, there is no allowance for an additional $20 disregard to be deducted from the income limit. Neither the state nor federal regulations allow for an additional $20 to be deducted from the income limit in calculating income eligibility.

The Respondent showed by a preponderance of evidence that it correctly calculated the Appellant's income in its decision that he was over the income limit for MPA eligibility. The Respondent's decision to terminate the Appellant's MPA benefits is affirmed.

CONCLUSIONS OF LAW

1) Policy establishes the income eligibility guidelines for MPA program benefits in accordance with federal authority.

2) The Appellant's income of $1,829, less the $20 disregard, equals $1,809.

3) The lowest category of MPA, QI, has an income limit of 135% of FPL, or $1,789.

4) The Appellant's calculated monthly income exceeds the allowable income limit for MPA eligibility.

5) The Respondent correctly closed the Appellant's QI benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to close the Appellant's QI benefits.

ENTERED this 15th day of September 2026.

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Lori Woodward**,** Certified State Hearing Officer