WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

Appellant,

v. **Action Number: 26-BOR-2385**

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 . 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 26, 2026.

The matter before the Hearing Officer arises from the July 13, 2026 decision by the Respondent to deny the Appellant's application for Medicare Premium Assistance (MPA) benefits.

At the hearing, the Respondent appeared by Christina McConnell, Economic Services Worker, Senior. The Appellant was represented by his wife, . Appearing as a witness for the Appellant was . 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 denial, dated July 13, 2026
- D-3 WV Income Maintenance Manual (IMM), Chapter 3, §3.15.3
- D-4 WV IMM, Chapter 4, Appendix A

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 June 30, 2026, the Appellant applied for benefits, including Medicare Premium Assistance (MPA) benefits.

3) The Appellant receives unearned income from the Social Security Administration (SSA) in the amount of $2,114.90.

4) The Appellant's spouse is reported to have no income, not entitled to Medicare Part A or B benefits, and is not in long-term care.

5) The Respondent determined that the Appellant was over the allowable income limit for an individual and issued a denial notice to the Appellant on July 13, 2026. (Exhibit D-2)

6) The allowable income limit for MPA for an individual cannot exceed $1,796. (Exhibit D-4)

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.
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 3, §3.15.1.A Who Must Be Included? Only the individual or spouses who are eligible for QMB, SLIMB, or QI-1 are included in the AG.

WV IMM, Chapter 3, §3.15.2.C Eligible Individual with Ineligible Spouse – No Medicaid LTC Services: Consider the income of the ineligible spouse to determine if it must be deemed. See Chapter 4 for how to determine if the spouse's income is deemed.

WV IMM, Chapter 3, §3.15.3.C Eligible Individual with Ineligible Spouse, No Income Deemed – No Medicaid LTC Services: The income limit for a single individual is used.

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.

DISCUSSION

The Appellant receives Medicare benefits and has income from the Social Security Administration (SSA) of $2,114.90 per month. On June 30, 2026, the Appellant applied for the Respondent's assistance programs, including MPA. On July 10, 2026, the Respondent's worker processed the Appellant's application and determined that he was over the income limit for MPA eligibility. The Appellant appeals the Respondent's decision stating that the Respondent erred in not counting his spouse in the eligibility determination. The Appellant's spouse has no income, not Medicare Part A or B eligible, and is not in long-term care. The Appellant's representative, believes that the Respondent is not following the federal regulations in family size determination.

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). Under the IMM, the policy specifically excludes spouses who are ineligible for Medicare Part A or B, who are not in long-term care, and who do not have income, to be excluded, and to determine eligibility based on the income limit for an individual.

The Respondent's policy specifically mandates that if eligible spouses are both members of the assistance group (AG), they must receive the same level of coverage, QMB, SLIMB, or QI-1. However, only the individual or spouses who are eligible for QMB, SLIMB, or QI-1 are included in the AG. The applicant's family size is considered in MPA determination. Thus, because the Appellant's spouse is not eligible for Medicare Part A or B, has no deemed income, and is not in long-term care, policy mandates that the income limit for an individual be used.

The Appellant's monthly gross income of $2,114.90, less the $20 disregard, is $2,094.90, or 210% of the Federal Poverty Level (FPL). The highest qualifying income level allowed by policy is under the QI category of MPA is 135% FPL or $1,796 for an individual. The Respondent showed by a preponderance of evidence that it correctly determined that the Appellant was over the allowable income for MPA eligibility.

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 $2,094.90, which is over the allowable MPA coverage limit for an individual.

3) The IMM policy incorporates the eligibility determinations set forth in the State's buy-in agreement.

4) The IMM policy specifically states that eligible individuals with spouses who are ineligible for Medicare Part A or B with no deemed income and who are not in long-term care, are considered under the income for individuals.

5) The Respondent's spouse is not eligible for Medicare Part A or B, is not in long-term care, and has no deemed income.

6) The Respondent correctly denied the Appellant's MPA application.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's MPA application.

ENTERED this 9th day of September 2026.

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Lori Woodward**,** Certified State Hearing Officer