June 26, 2024

[redacted]

RE: [redacted] v. WV DoHS
ACTION NO.: 24-BOR-2113

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 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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

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

cc: Brandy Burdette, DoHS
Dawn Forro, DoHS
Mark Paree, DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2113**

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 May 22, 2024.

The matter before the Hearing Officer arises from the Respondent's April 25, 2024 decision to deny the Appellant eligibility for Adult Medicaid benefits.

At the hearing, the Respondent was represented by Brandy Burdette, [redacted] DoHS. The Appellant appeared and represented himself. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:
D-1 West Virginia Income Maintenance Manual (WVIMM) policy excerpts
D-2 Email Correspondence
D-3 Notice, dated April 25, 2024

Appellant's Exhibits:
A-1 Social Security Administration Benefit Verification Letter, dated December 26, 2024.

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 received Adult Medicaid benefits (Exhibit D-3).

2) In April 2024, the Appellant's wife completed the AG's Medicaid eligibility review.

3) At the time of the April 2024 review, the AG reported a three-person household.

4) The Respondent assessed the AG's income through a review of the State Online Query (SOLQ) and by the Appellant's wife's submitted paystubs.

5) On April 25, 2024, the Respondent issued a notice advising the Appellant that beginning on June 1, 2024, he was no longer eligible for Adult Medicaid because his income exceeded the eligibility limit (Exhibit D-3).

6) The Respondent's decision was based on a three-person household (Exhibit D-3).

7) The Respondent considered $1,933.51 in earned income and $1,045.70 in unearned income (Exhibit D-3).

8) On December 26, 2023, the Social Security Administration issued a notice stating the Appellant became disabled under Social Security Administration (SSA) rules on May 29, 2020 (Exhibit A-1).

9) The Appellant does not receive a Supplemental Security Income Payment (Exhibits D-2 and A-1).

10) On April 30, 2024, the Respondent reviewed a copy of an April 24, 2024 SSA letter corroborating the Appellant's disability status (Exhibit D-2).

11) The Respondent provided the Appellant with the December 26, 2023 notice on the day of the hearing (Exhibit D-3).

12) The Appellant is not yet age 65.

13) The Appellant is not a Medicare recipient.

APPLICABLE POLICY

WVIMM § 10.6.2 ***Client Reporting Requirements*** provides that clients must report all changes in circumstances, including changes to income, assets, and household composition. The client must report changes as soon as possible after he becomes aware of them. This allows the Worker to update the case and allows for advance notice if the reported information results in an adverse action.

When a client reports a change during the Medicaid certification period that affects eligibility, the Worker must only request the information on the change reported.

WVIMM § 10.6.5.A *AG Closures* provides that when the client's circumstances change to the point he becomes ineligible, the AG is closed.

WVIMM § 10.6.5.B *Consideration of Eligibility under Other Coverage Groups* provides that in no instance is Medicaid under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This evaluation is done before the client is notified that his Medicaid eligibility will end. Eligibility is evaluated based on case record information. The AG does not remain active while the MRT decision is pending.

WVIMM § 3.5 *Medicaid General Eligibility* provides that the Medicaid Assistance Group (AG) is composed of the individual(s) who meet(s) the eligibility requirements for coverage under a specific Medicaid coverage group. Some coverage groups require the determination of an income group (IG) to determine countable income and a needs group (NG) for comparison to appropriate needs standards to determine financial eligibility.

WVIMM § 3.7 *Adult Group* provides that this Medicaid coverage is provided to individuals age 19 or older and under age 65 who are not otherwise eligible for and enrolled in another categorically mandatory Medicaid coverage group, and are not entitled to or enrolled in Medicare Part A or B. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

WVIMM § 3.13 *Supplemental Security Income (SSI) Recipients* provides in relevant sections: Only the SSI recipient or an individual who is otherwise entitled to SSI is included in the AG. This includes an individual who is otherwise entitled to an SSI payment but does not receive it due to a repayment.

WVIMM § 3.13.3 *The Needs Group (NG)* provides that SSA determines the need for SSI. Receipt of or entitlement to SSI is the only eligibility factor.

WVIMM § 3.7.2 *The MAGI Household Income Group (IG)* provides that the income of each member of the individual's MAGI household is counted. The income group is determined using the MAGI methodologies established in Section 3.7.3.

WVIMM § 3.7.3 *The MAGI Household Needs Group (NG)* provides that for applying MAGI methodology, each spouse must be included in the MAGI household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse. Children being claimed as tax dependent by a parent must be included in the tax filer's Medicaid household.

WVIMM § 4.3.2 *Countable Sources of Income* provides that for determining MAGI Medicaid Adult Group eligibility, wages, and social security benefits are countable sources of income.

WVIMM § 6.3.4.B *Worker Requested Verification – State On-Line Query (SOLQ)* provides the agency direct access to SSA's databases.

WVIMM § 13.6.2 *When The Applicant Has Received SSI Based on Disability or Blindness* provides that if it is verified that the SSI payment was terminated for some reason other than the lack of disability or blindness, medical eligibility is presumed before obtaining medical reports. The Worker then follows the usual procedures to obtain medical reports, complete the DFA-RT-1, Social Summary Outline and submits the case to the MRT for a final decision, etc. See Section 13.3 for instructions regarding completion of the DFA-RT-1

WVIMM § 13.10.1.A *Client is Blind or Disabled* provides that if the applicant was found to be disabled and the case was not presumptively approved, then the application is approved, or the individual is added to the assistance group (AG) whichever is appropriate. If the case was presumptively approved, or the individual was already added, a recording of the final decision must be made in the eligibility system.

WVIMM § 23.10.4 *Adult Group* provides that to be eligible, the AG's income must be equal to or below 133% of the Federal Poverty Level (FPL). For a three-person household, 133% FPL is $2,862.

WVIMM Chapter 4, Appendix A *Income Limits* demonstrates that 100% FLP for a 3-person AG is $2,152.

WVIMM §§ 4.7.3 *MAGI-Based Income Disregard* and 4.7.3.A *MAGI-Based Income Disregards Examples* provide in relevant sections**:**

The only allowable income disregard is an amount equivalent to five percentage points of 100% of the Federal Poverty Level (FPL) for the applicable MAGI household size. The 5% FPL disregard is not applied to every MAGI eligibility determination and should not be used to determine the MAGI coverage group for which an individual may be eligible. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

Adult Group Example 1: A client has a MAGI household income of 137% of the FPL. The 5% FPL disregard would be applied to bring his income below 133% of the FPL for the Adult Group.

WVIMM § 4.7.4 *Determining Eligibility* provides in relevant sections:

The AG's income must be at or below the applicable MAGI standard for the MAGI coverage groups.

Step 1: Determine the MAGI-based gross monthly income …

Step 2: Convert the MAGI household's gross monthly income to a percentage of the FPL by dividing the current monthly income by 100% of the FPL for the household size. Convert the result

to a percentage. If the result from Step 2 is equal to or less than the appropriate income limit, no disregard is necessary, and no further steps are required.

Step 3: If the result from Step 2 is greater than the appropriate limit, apply the 5% FPL disregard by subtracting five percentage points from the converted monthly gross income to determine the household income.

Step 4: After the 5% FPL income disregard has been applied, the remaining percent of FPL is the final figure that will be compared against the applicable modified adjusted gross income standard for the MAGI coverage groups.

DISCUSSION

The Respondent completed an eligibility review with the Appellant's wife in April 2024 and determined the AG's income exceeded the Adult Medicaid eligibility limit. The Respondent argued that the AG's income is within the eligibility limit and that he should be automatically determined eligible for Medicaid because of his disability status.

The Respondent bears the burden of proof and had to determine by a preponderance of evidence that the Appellant's income exceeded the Medicaid eligibility limit for Adult Medicaid and that the Respondent correctly assessed his eligibility for other coverage groups before terminating his Adult Medicaid benefits.

The Board of Review must follow the policy and cannot change the policy or award eligibility beyond the circumstances provided in the policy. This Hearing Officer is unable to grant the Appellant relief by awarding income exclusions or Medicaid eligibility exceptions beyond the policy provisions.

The Appellant argued that since 2017, his physician statements have exempted him from WV WorkForce requirements. The Appellant testified that he believes his Medicaid termination is punitive because he is unable to participate in WV WorkForce. The Adult Medicaid and SSI programs do not have a work requirement to establish eligibility; therefore, arguments related to this issue were given no weight in the decision of this Hearing Officer.

Assistance Group Size

During the hearing, the Appellant argued his eligibility was incorrectly based on a three-person household and should have been considered a four-person household because his stepson moved into the home a few months before the hearing. The Appellant testified his stepson did not have an income. The Appellant argued that the Respondent was aware his stepson had moved into the household because his stepson received Supplemental Nutrition Assistance Program benefits from the Respondent and utilized the Appellant's address to receive those benefits. The Appellant testified that his worker may not have been aware of his son living in the household, but his stepson's worker was aware.

Before eligibility can be determined based on a four-person household, the Appellant was required to report the addition of an adult child moving into the home. Reports by another individual in a separate case regarding that individual's residence do not constitute a member of the Appellant's AG reporting a change in the household composition. During the hearing, the Appellant testified that his wife, who was not present at the hearing, completed the eligibility review and interview. He testified that his stepson comes and goes from the residence. The Appellant testified that his wife is thorough when completing the necessary paperwork and that if she omitted information, it was unintentional and because of memory issues related to a stroke. Sufficient information was not presented during the hearing to determine when the Appellant's stepson began staying in the home.

The Respondent's representative testified that the Appellant's completed review form reflected a three-person household. Because the Appellant's AG did not report a new household member during the Medicaid eligibility review, the Respondent correctly assessed the AG's eligibility based on a three-person household. However, as the Appellant reported information during the hearing that conflicts with the Respondent's record and it is unclear whether the Appellant's stepson resides in the home, the Respondent should note the Appellant's reported change and consider his report according to the policy.

Adult Group Medicaid Eligibility

The Appellant argued that the family's living expenses impeded their ability to financially afford the Appellant's necessary medical expenses. To be eligible for Adult Group Medicaid, the AG's income could not exceed $2,862, or 133% of the Federal Poverty Level (FPL). The Respondent's representative testified that the Appellant's household's countable income was $2,979.21 and exceeded the 133% FPL income eligibility limit for a three-person household.

The Appellant argued that as of January 2024, his annual household income was below the Medicaid annual income eligibility limit for a three-person household. The policy instructs that annual income must be converted to a monthly amount when determining eligibility. Each party was permitted an opportunity to present exhibits to support their case. The submitted evidence did not reveal an annual amount of income for the Appellant's household. Therefore, the monthly amount could not be converted based on the household's annual income.

During the hearing, the Respondent's representative testified that the Appellant's AG's unearned income was $1,432.32 from the Appellant's wife. The Appellant contested the amount of his wife's unearned income and testified that she receives around $1,000 and does not receive $1,400. The Respondent's representative testified that the Appellant's wife receives $1,045.70 in social security income. The Respondent's representative clarified that she checked via internal systems and determined the AG received $442 monthly child support income but did not consider the child support amount in the AG's Medicaid eligibility determination. The Respondent's provide amounts of $1,045.70 social security income + $442 child support income equals $1,487.70, not $1,432.32. The Respondent's testimony regarding the amount of unearned income was determined to be unreliable as the Respondent's representative's calculations could not be confirmed based on the submitted evidence.

The Respondent did not submit copies of the verifications she used to determine the amount of the Appellant's earned and unearned income. Because the Respondent's representative calculations were not supported by her testimony and no supporting records, such as a copy of the review form or paystub verifications, were submitted for evidential review, the accuracy of the amount of income used to determine the Appellant's eligibility could not be confirmed.

The Respondent considered $1,933.51 earned income and $1,045.70 unearned income when determining the AG's Medicaid eligibility. During the hearing, the Respondent's representative testified that the Appellant's wife reported during her eligibility review that she received a raise. The Respondent testified she calculated the AG's income based on the paystub information submitted by the Appellant's wife. The Appellant did not refute his wife's submitted paystub as proof of the AG's income; however, he contested the amount of unearned income and argued the amount of annual income fell within the eligibility limit. The Hearing Officer's attempt to recreate the Appellant's calculations based on the presented information was unsuccessful.

Establishing the correct amount of countable income by a preponderance of the evidence is essential for corroborating the Respondent's calculations and determining the appropriate FPL percentage of the household's income when determining the Appellant's Adult Medicaid eligibility. The Respondent failed to prove the amount of the AG's countable income by a preponderance of the evidence.

Other Medicaid Eligibility

The Respondent argued that before terminating the Appellant's Adult Medicaid eligibility, he was evaluated for other Medicaid coverage groups. The emails submitted for review reflect that the Respondent's worker exchanged emails internally inquiring about the proper handling of the Appellant's SSA letter.

The Appellant argued that because he receives social security disability, he should automatically be granted Medicaid eligibility. The Appellant testified that he doesn't receive income from social security but has been determined disabled. He testified that his wife's income negates his ability to draw SSI payments. The evidence revealed that the Appellant became disabled under the SSA rules on May 29, 2020, but did not receive an SSI payment related to his disability.

The policy provides that only SSA may determine eligibility for SSI payments. The evidence revealed the Appellant is not financially entitled to receive an SSI payment. According to the policy, when the reason for lack of SSI payment is something other than the lack of disability, medical eligibility is presumed. The policy instructs that the Respondent must follow the usual procedures to obtain medical reports, complete the documentation specified by the policy, and submit the case to the MRT for final decision. The policy provides that if the Appellant was found to be disabled and the case was not presumptively approved, then, the application is approved or the individual is added to the AG, whichever is appropriate. The submitted evidence did not indicate that the Respondent completed this process to evaluate the Appellant's eligibility for MRT Medicaid based on disability.

CONCLUSIONS OF LAW

1) To be eligible for Adult Group Medicaid, the three-person AG's income must be equal to or below 133% of the FPL.

2) The preponderance of evidence failed to establish the amount of the AG's countable income.

3) The Respondent failed to prove by a preponderance of evidence that the Appellant was ineligible for Adult Medicaid because the AG's income exceeded the 133% FPL income eligibility limit.

4) Because the evidence failed to prove the AG's income exceeded the Medicaid eligibility limit, the Respondent must retroactively reinstate the Appellant's Adult Medicaid eligibility.

5) The Social Security Administration determines the income eligibility for SSI payment entitlement.

6) The preponderance of evidence revealed that the Appellant was not eligible for SSI payment entitlement at the time of the Respondent's decision.

7) The preponderance of evidence failed to prove that the Appellant was assessed for eligibility for MRT Medicaid.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate his Adult Medicaid eligibility. It is hereby **ORDERED** that the Appellant's Adult Medicaid benefits be reinstated retroactively to the date of termination. The matter is **REMANDED** for verification of the AG's income and assessment for MRT Medicaid eligibility.

ENTERED this 26th day of June 2024

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Tara B. Thompson, MLS
State Hearing Officer