June 24, 2024

[redacted]

RE: [redacted] v. WV DOHS
ACTION NO.: 24-BOR-2194

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 assure 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: Keith Henry, WVDOHS/BFA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2194**

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 June 11, 2024.

The matter before the Hearing Officer arises from the May 10, 2024 decision by the Respondent to terminate the Appellant's Medicaid benefits.

At the hearing, the Respondent appeared by Keith Henry, Economic Services Supervisor. The Appellant appeared *pro se*. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Hearing Summary
D-2 Completed Medicaid/WV CHIP review form (MREV), signed March 1, 2024
D-3 Verification checklist (DFA-6), dated April 8, 2024
D-4 Notice of denial, dated April 22, 2024
D-5 Notice of denial, dated May 10, 2024
D-6 WV Income Maintenance Manual (WV IMM), Chapter 4, §4.7
D-7 WV Income Maintenance Manual (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 and her husband were recipients of Medicaid benefits.

2) On March 1, 2024, the Appellant submitted a Medicaid review. (Exhibit D-2)

3) The Appellant's review was processed on April 8, 2024. (Exhibit D-1)

4) On April 8, 2024, the Respondent requested that the Appellant verify the Appellant's husband's income by April 18, 2024. (Exhibit D-3)

5) On April 22, 2024, the Respondent closed the Appellant's Medicaid benefits because she did not return the requested information. (Exhibit D-4)

6) On May 6, 2024, the Appellant returned the requested verification. (Exhibit D-1)

7) On May 10, 2024, the Respondent sent notification to the Appellant that the assistance group (AG) was over the allowable income for Medicaid eligibility. (Exhibit D-5)

APPLICABLE POLICY

Code of Federal Regulations, 42 CFR §435.119 provides the following information concerning Adult Medicaid coverage:

Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

(a) ***Basis.*** This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.

(b) ***Eligibility.*** Effective January 1, 2014, the agency must provide Medicaid to individuals who:

(1) Are age 19 or older and under age 65;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and

(5) Have household income that is at or below 133 percent FPL for the applicable family size.

WV IMM, Chapter 23, §23.10.4, states, in part**:** As a result of the Affordable Care Act (ACA), the Adult Group was created, effective January 1, 2014. Eligibility for this group is determined using MAGI methodologies established in Section 4.7. Medicaid coverage in the Adult Group is provided to individuals who are aged 19 or older and under age 65.

…

To be eligible for the Adult Group, income must be equal to or below 133% of the Federal Poverty Level (FPL).

WV IMM, Chapter 3, §3.7.3, states, in part: The needs group is the number of individuals included in the Modified Adjusted Gross Income (MAGI) household size based upon the MAGI rules for counting household members.

WV IMM, Chapter 4, §4.7.2, explains that eligibility for the MAGI coverage group is determined by using the adjusted gross income (for each member of the MAGI household whose income will count) for the current month. The MAGI differs from the adjusted gross income because MAGI accounts for additions and adjustments. The worker uses the budgeting method established in Section 4.6.1, Budgeting Method, to anticipate future income amounts, consider past income sources, and build monthly income amounts based upon the applicant's reported income.

WV IMM, Chapter 4, §4.7.3, states that 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.

WV IMM, Chapter 4, §4.6.1.D, explains that conversion of income to a monthly amount is accomplished by multiplying an actual or average amount as follows:

- Weekly amount x 4.3
- Bi-weekly amount (every two weeks) x 2.15
- Semi-monthly (twice/month) x 2.

WV IMM, Chapter 4, §4.7.4, states that the applicant's household income must be at or below the applicable MAGI standard for the MAGI coverage groups.

> Step 1: Determine the MAGI-based gross monthly income for each MAGI household income group (IG).
>
> 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.

West Virginia Income Maintenance Manual Chapter 4, Appendix A, sets the income limit for a two-person MAGI Medicaid Assistance Group is $2,266 (133% of the Federal Poverty Level)

DISCUSSION

The Appellant and her husband were recipients of Medicaid. On March 1, 2024, the Appellant submitted her Medicaid eligibility review. On April 8, 2024, the Respondent sent a verification request to the Appellant requesting verification of her husband's hours and gross income he received between January 31 and February 29, 2024, from [redacted] The verification request also stated that the information was due by April 18, 2024. The requested verification was not returned. On April 22, 2024, the Respondent sent the Appellant notification that her Medicaid benefits were denied due to not returning the requested information. On May 6, 2024, the Respondent received the requested verification. However, when the Respondent processed the income information, it was determined that the Appellant's AG was over the income limit for Medicaid eligibility and notification of denial was sent on May 10, 2024.

The Appellant testified that her husband's job is not permanent, is seasonal, and that his income fluctuates. No evidence was submitted in support of the Appellant's statements. Additionally, the Appellant stated that she suffers from medical issues which necessitate her having insurance, which her job does not offer.

Because the Appellant failed to submit the requested income verification for her husband by the established due date of April 18, 2024, the Respondent correctly closed the Appellant's Medicaid benefits. Because the Respondent processed the submitted income information received from the Appellant on May 6, 2024, which showed that the AG was over the income limit for Medicaid eligibility, the Respondent correctly denied the Appellant's application.

CONCLUSIONS OF LAW

1) Policy requires verification of income at all applications and redeterminations.

2) Because the Appellant failed to return the requested income verification, the Respondent correctly closed the Appellant's Medicaid benefits.

3) Because the Appellant returned income information after the closure of the Appellant's Medicaid benefits which showed that the AG was over the income limit, the Respondent correctly denied Medicaid benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's April 22, 2024 decision to close the Appellant's Medicaid benefits, and its May 10, 2024 decision to deny the Appellant's Medicaid application. This decision does not preclude the Appellant from reapplying for benefits.

ENTERED this 24th day of June 2024.

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Lori Woodward**,** Certified State Hearing Officer