October 1, 2024

[redacted]

RE: [redacted] v. WV DoHS
ACTION NO.: 24-BOR-2697

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,

Angela D. Signore
State Hearing Officer
Member, State Board of Review

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

cc: Kara Pendleton, WV DoHS, Office of Constituent Services

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2697**

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 September 10, 2024, on an appeal filed July 17, 2024.

The matter before the Hearing Officer arises from the June 06, 2024 determination by the Respondent to terminate the Appellant's Modified Adjusted Gross Income (MAGI) Adult Medicaid eligibility and the denial of Medicaid Work Incentive (M-WIN) benefits due to household income exceeding the eligibility limits.

At the hearing, the Respondent appeared by Kara Pendleton, Department of Human Services (DoHS) Office of Constituent Services. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 West Virginia (WV) People's Access to Help (PATH) eligibility system printout of case comments
D-2 WV PATH eligibility system printout of employment income
D-3 WV PATH eligibility system printout of unearned income
D-4 WV PATH eligibility system printout of MAGI Medicaid Income Budget
D-5 WV DoHS Notice of Decision, dated June 06, 2024
D-6 WV PATH eligibility system printout of case comments
D-7 M-WIN Application, dated June 11, 2024; HIPAA Authorization(s); [redacted] Checking Account Statement; [redacted] prescription for [redacted]s; Handwritten note, dated Jun 12, 2024, and Paystubs for [redacted]
D-8 WV PATH eligibility system printout of employment income

D-9 WV PATH eligibility system printout of unearned income
D-10 WV DoHS Notice of Decision, dated July 15, 2024
D-11 West Virginia Income Maintenance Manual (WVIMM) §§ 26.6.5 through 26.6.6.B
D-12 WVIMM §§ 26.6.1 through 26.6.4

Appellant's Exhibits:

A-1 [redacted] Treatment Letter for [redacted]
A-2 [redacted] Billing Statement for [redacted]
A-3 [redacted] Letter for [redacted]

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 a recipient of Modified Adjusted Gross Income (MAGI) Adult Medicaid benefits for an assistance group (AG) of one (1). (Exhibits D-1 through D-10)

2) On or before May 29, 2024, the Appellant reported the onset of Retirement, Survivors, and Disability Insurance (RSDI) program benefits in the amount of $1,751 per month.

3) Through an online data exchange with the Social Security Administration (SSA), the Respondent verified that the Appellant began receiving RSDI program benefits in the amount of $1,751 per month beginning October 2023. (Exhibit D-9)

4) The maximum monthly gross income limit for Adult Medicaid program benefits for a one (1) person AG is $1,670, or 133% of the Federal Poverty Level (FPL). (Exhibits D-3 through D-5)

5) On June 06, 2024, the Respondent issued a notice of decision to the Appellant informing him that, effective July 01, 2024, his Adult Medicaid benefits would end based on excessive income and failure to complete an eligibility review. (Exhibit D-5)

6) On June 12, 2024, the Appellant applied for Medicaid Work Incentive (M-WIN) program benefits. (Exhibits D-6 through D-7, and D-10)

7) As verified by paystubs and checking account information included with the Appellant's M-WIN application, the Respondent updated the Appellant's average gross monthly earned income to $861.05, beginning July 2024. (Exhibit D-8)

8) On July 15, 2024, after the Respondent evaluated the Appellant for M-WIN program benefits, the Respondent issued a notice of decision to the Appellant advising that his application was being denied due to the Appellant's RSDI income ($1,751) exceeding the unearned income eligibility limit of $943. (Exhibits D-7 and D-10)

9) The Respondent failed to evaluate the Appellant for other types of Medicaid before issuing the notice of termination on June 06, 2024.

10) The Appellant contested the Respondent's June 06 and July 15, 2024 decisions and requested a Fair Hearing on July 17, 2024.

11) The Appellant's income is excessive for Adult Medicaid and M-WIN eligibility.

12) The Appellant failed to complete his Adult Medicaid eligibility review.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 1.2.1.C provides, in part:

> It is the Worker's responsibility to explain and make available all of the Department of Human Services' (DOHS) programs for which the applicant could qualify. The Worker must evaluate potential eligibility for all programs based on the available information, unless the applicant specifically states he is not interested in being considered for a specific program.
>
> When an applicant has been evaluated and eligibility is confirmed, a client notice is issued from the eligibility system to inform the applicant that he may be eligible for a benefit for which he did not apply and that he must contact his local office for information or to apply.

WVIMM § 1.2.2.B provides, in part:

> Periodic reviews of total eligibility for recipients are mandated by federal law. These are redeterminations and take place at specific intervals, depending on the program or Medicaid coverage group. Failure by the client to complete a redetermination will result in termination of benefits. If the client completes the redetermination process by the specified program deadline(s) and remains eligible, benefits must be uninterrupted and received at approximately the same time.
>
> The redetermination process involves basically the same activities described in Application Process above. Eligibility system changes and client notification of any changes resulting from the redetermination conclude the process.

WVIMM § 1.2.2.C provides, in part:

> While a redetermination is a required periodic review of total eligibility, a review may be conducted at any time on a single or combination of questionable eligibility factor(s). The case maintenance process may involve a review or activities that update the Department's information about the client's circumstances between the application and first redetermination and between redeterminations. Changes in eligibility or the benefit amount may occur. If so, eligibility system action and client notification of any changes are required. Some special situations may require a

more formal review process. This may be a special procedure to target an error problem.

WVIMM § 1.2.11 provides, in part:

Each program and Medicaid coverage group has its own policies related to redetermination. Please see the program-specific sections for details.

NOTE: At redetermination for one program or Medicaid coverage group, the client may want to apply for an additional benefit. If so, the same DFA-2 or WV PATH application is used as an application for the new benefit and a redetermination for the active AG, regardless of the program or Medicaid coverage group.

Medicaid and WVCHIP NOTE: If coverage is closed for failure to submit a redetermination form, or necessary information, but the client responds and provides the information within 90 days of the effective date of closure, the Worker must determine eligibility in a timely manner without requiring a new application. Eligibility may be back dated up to three months, provided all eligibility requirements were met.

WVIMM § 1.6.6 provides, in part:

When the application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay and coverage must be backdated for any prior eligibility period. This may be more than three months if due to an agency error.

If the Department simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the Department acted in a timely manner.

WVIMM § 1.6.11.A provides, in part:

When an individual is ineligible for MAGI Medicaid or WVCHIP due to income, and he attests to disability, he may be eligible for an SSI-Related, Medicaid Work Incentive Network (M-WIN) or other Medicaid Group. During this time, he may receive Marketplace benefits. If approved for other non-MAGI Medicaid coverage, the Marketplace is electronically notified.

WVIMM § 3.7.1.B provides, in part:

These individuals cannot be included in MAGI Medicaid:

- Individuals eligible for these categorically mandatory coverage groups:
    - Supplemental Security Income (SSI)
    - Deemed SSI
    - Parents/Caretakers

- Pregnant Women
- Children Under Age 19
- Former West Virginia Foster Children

- Individuals entitled to or enrolled in Medicare Part A or B

- Parents or other caretaker relatives living with a dependent child under the age of 19, unless the child is also receiving benefits under Medicaid, WVCHIP, or other minimum essential coverage (MEC).

WVIMM § 4 Appendix A provides, in part:

For a one (1) person Assistance Group (AG), the income limit is $1,670 = 133% FPL
For a one (1) person Assistance Group (AG), 100% of the FPL = $1,255

WVIMM § 4.13.1 provides, in part:

Countable income is determined the same way it is for Supplemental Security Income (SSI)-Related Medicaid. See Section 4.14.3. The same disregards and deductions used for SSI-Related Medicaid are applied. See Section 4.14.2.

Once countable income is determined, it is compared to 200% of the Federal Poverty Level (FPL), rather than the Medically Needy Income Level (MNIL), to determine financial eligibility. If the countable income exceeds 200% of the FPL, the client is ineligible as a QDWI.

WVIMM § 4.14.4.J provides, in part:

To be eligible for Medicaid, the Income Group's (IG) monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are subtracted from the income for the six-month POC, until the income is at, or below, the MNIL for the Needs Group (NG) size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid.

WVIMM § 6.3.4.B provides, in part:

SOLQ provides direct access to SSA's databases. The Worker must initially use the Hub for evaluating eligibility for MAGI Medicaid and WVCHIP coverage groups, the Income and Eligibility Verification System (IEVS) data exchange for all other programs, and SOLQ last.

Information received includes SSN verification, as well as SSI and RSDI details. Requests can be made only for individuals known to the eligibility system within the previous five years. This information is considered verified upon receipt for SNAP and is not subject to independent verification.

WVIMM § 9.3.1.A provides, in part:

The Department of Human Services (DOHS) buys in for clients in the following Medicaid categories when they are eligible for Medicare.

- Supplemental Security Income (SSI) Recipients
  - SSI recipients who are age 65 or older and who are enrolled in Medicare Part B
  - SSI recipients who are under age 65 and who have been receiving monthly Social Security Administration (SSA) Disability or Railroad Retirement Board (RRB) Benefits under Title II of the Social Security Act for 24 months
- Deemed SSI Recipients
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary program (SLIMB)
- Qualified Individual-1 (QI-1)
- Qualified Disabled Working Individuals (QDWI)

WVIMM § 10.8.1 provides, in part:

When a change in income is reported, eligibility for the AG must be re-evaluated. Changes include the onset or termination of income, as well as income increases and decreases. The reported change(s) may not result in any eligibility change, or they may result in AG closure. Advance notice is required for any adverse action, and the AG must be evaluated for all other Medicaid coverage groups and West Virginia Children's Health Insurance Program (WVCHIP) prior to closure.

WVIMM § 10.8.3 provides, in part:

The AG must be closed when the individual(s):

- Turns age 65;
- Begins receiving Medicare Part A or B; or [emphasis added]
- Are parents or other caretaker relatives living with a dependent child under the age of 19 and the child no longer receives minimum essential coverage.

The AG is closed the month following the month of the change and after advance notice for the adverse action. The AG must be evaluated for all other Medicaid coverage groups prior to closure.

WVIMM § 23.8.1 provides, in part:

The client cannot be expected to know which Medicaid coverage group to apply for. When the client expresses an interest in applying for Medicaid, the Worker must explore eligibility for all Medicaid coverage groups.

The Worker does not have to take and process applications for all coverage groups, but Medicaid eligibility cannot be denied until the client has been considered for

each coverage group. If the client is eligible under more than one coverage group, he is approved for the one that will provide him with the most benefits in the shortest time frame.

Certain programs, including long-term care programs, require a medical and/or other determination by an agency other than Division of Family Assistance (DFA) as part of the eligibility process. The financial determination is made by the Department of Human Services (DOHS). When an applicant's medical eligibility for, or enrollment in these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

WVIMM § 23.9 provides, in part:

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.

WVIMM § 23.10.4 provides, in part:

As a result of the ACA, the Adult Group was created effective January 1, 2014. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

Medicaid coverage in the Adult Group is provided to individuals who meet the following requirements:

- They are age 19 or older and under age 65;
- They are not eligible for another categorically mandatory Medicaid coverage group:

  - ➢ SSI
  - ➢ Deemed SSI
  - ➢ Parents/Caretaker Relatives
  - ➢ Pregnant Women

- ➢ Children Under Age 19
- ➢ Former Foster Children

- They are not entitled to or enrolled in Medicare Part A or B; and
- The income eligibility requirements described in Chapter 4 are met.

Parents or other caretaker relatives living with a dependent child under the age of 19 are not eligible for Medicaid in the Adult Group unless the child is receiving benefits under Medicaid, WVCHIP, or otherwise enrolled in minimum essential health coverage (MEC).

WVIMM § 23.11.3 provides, in part:

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.

WVIMM §§ 23.11.6 and 26.2.1 provide, in part:

The Medicaid Work Incentive (M-WIN) full-coverage Medicaid group was established to assist individuals with disabilities in becoming independent of public assistance by enabling them to enter the workforce without losing essential medical care.

To be eligible, the individual must:

• Be at least age 16, but not yet age 65;
• Be disabled as defined by the SSA;
• Be engaged in competitive employment; and,
• Pay all required enrollment fees and premiums.

Income: $3,138, or 250% of the Federal Poverty Level (FPL) – When Unearned Income is at or below the Supplemental Security Income (SSI) Payment Level.

No spenddown provision.

Assets: $2,000 – Individual; $3,000 – Individual with Spouse.

WVIMM § 26.2.3 provides, in part:

> The applicant must be disabled as defined by the Social Security Administration (SSA). The SSA or the State Medical Review Team (MRT) may determine the disability. Disability, for this coverage group, is defined as a medically determined physical or mental condition that has lasted, or is expected to last, a year or more, or is expected to result in death. The disability definition for individuals under age 18 is found in Section 13.2.1.B.

WVIMM § 26.2.4 provides, in part:

> The applicant must be engaged in competitive employment. There is no minimum number of hours a client must be employed for M-WIN eligibility. Competitive employment includes self-employment and non-traditional work which is compensated at or above the federal minimum hourly wage in a setting that also includes, or could include, non-disabled individuals.

DISCUSSION

The Appellant became a recipient of disability benefits through the Social Security Administration in October 2023. On or about May 29, 2024, the Appellant visited the [redacted] DoHS to report that he is now receiving $1,751 in Retirement, Survivors, and Disability Insurance (RSDI) program benefits. On June 06, 2024, the Respondent issued a notice of decision advising the Appellant that his eligibility for Adult Medicaid was being terminated beginning July 01, 2024, due to excessive income and failure to complete an eligibility review. The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant was not eligible for Adult Medicaid benefits due to excessive income and failure to complete an eligibility review, and that he was further evaluated for other Medicaid coverage groups, including SSI-Related Medicaid with a spenddown. The Respondent must further prove that the Appellant's M-WIN application was correctly denied on the basis of excessive income.

At the time of the hearing, the Respondent testified that in response to the Appellant having reported the onset of RSDI program benefits, an unearned income of $1,751 per month was added to the Appellant's previously reported earned income amount of $1,311.41 per month. Once added, the Appellant's countable net income was recalculated and the Appellant's eligibility for Adult Medicaid was terminated. On June 06, 2024, the Respondent issued a notice of decision advising the Appellant that his eligibility for Adult Medicaid was being terminated beginning July 01, 2024, due to excessive income and failure to complete an eligibility review. The Respondent further testified that as of the date of the hearing, the Appellant's Adult Medicaid eligibility review form has not been received. While there was no testimony or evidence provided to establish a due date for the Appellant's eligibility review, the Appellant did not contest the Respondent's testimony or deny failing to complete his review.

Policy stipulates that periodic reviews of total eligibility for recipients are mandated by federal law. Failure by the client to complete a redetermination will result in termination of benefits. Policy further provides that the maximum monthly gross income limit for Adult Medicaid program benefits for a one (1) person AG is $1,670, or 133% of the Federal Poverty Level. Because the

Appellant's monthly gross income of $3,062.41 is excessive for Adult Medicaid purposes, the Respondent's decision to terminate benefits based on excessive income and failure to complete an eligibility review was correct.

On June 12, 2024, the Appellant completed an application for Medicaid Work Incentive (M-WIN) program benefits. The Respondent testified that a notice of decision was issued on July 15, 2024, advising the Appellant that his application was denied because his unearned income exceeded the eligibility limit. The Appellant testified that, due to his multiple medical problems, Medicaid benefits are necessary in order to continue seeking care. Pursuant to policy, the income limit for M-WIN benefits is $3,138, or 250% of the federal poverty level, and total countable unearned income cannot exceed the SSI payment level of $943. Because the Appellant's unearned income of $1,751 is excessive for M-WIN eligibility purposes, the Respondent's decision to deny the June 2024 application is correct.

When questioned about whether the Department evaluated the Appellant's potential eligibility for other Medicaid programs prior to termination, the Respondent testified that Department was focused on the Appellant's potential M-WIN eligibility and other Medicaid programs were not considered. Pursuant to the policy an AG must [emphasis added] be evaluated for all other Medicaid coverage groups prior to closure. The Respondent may close the AG after [emphasis added] considering Medicaid eligibility under other coverage groups and before issuing notice that Medicaid eligibility will end. By the Respondent's own admission, the Appellant was not properly evaluated for all other types of Medicaid prior to his benefits being terminated. While the Appellant's income does exceed the Adult Medicaid and M-WIN eligibility limits, and the Appellant did not complete his eligibility review, the Respondent failed to evaluate the Appellant for all other Medicaid coverage groups, including SSI-Related Medicaid with a spenddown, prior to termination.

CONCLUSIONS OF LAW

1) To be eligible for Adult Medicaid benefits, the Appellant's gross monthly income must be at or below 133% of the Federal Poverty Level (FPL).

2) For a one (1) person Assistance Group (AG), the income limit is $1,670.

3) The Appellant's income exceeded the 133% FPL for a one (1) person Adult Medicaid AG.

4) The income limit for M-WIN benefits is $3,138, or 250% of the Federal Poverty Level, and total countable unearned income cannot exceed the maximum SSI payment level of $943.

5) The Appellant's income is excessive for M-WIN eligibility.

6) The Respondent failed to evaluate the Appellant for all Medicaid programs for which he may qualify prior to termination.

7) Because the Respondent failed to evaluate the Appellant for all Medicaid programs for which he may qualify, the Appellant was not evaluated for SSI-Related Medicaid with a spenddown prior to termination.

8) The Respondent must evaluate the Appellant for all Medicaid programs for which he may qualify, specifically SSI-Related Medicaid with a spenddown.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's action to terminate the Appellant's Adult Medicaid, since the Respondent failed to evaluate the Appellant for all Medicaid programs for which he may qualify, prior to termination. It is hereby **ORDERED** that the matter is **REMANDED** to the Respondent for further assessment of the Appellant's eligibility for all Medicaid coverage groups, specifically SSI-Related Medicaid with a spenddown. If found eligible, it is further **ORDERED** that the Respondent must backdate the Appellant's eligibility to the July 01, 2024 termination date. Subsequent notices of Medicaid eligibility determinations should include the Appellant's right to a fair hearing.

ENTERED this _____ day of October 2024.

_____

Angela D. Signore
State Hearing Officer