STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Inspector General
Board of Review

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Christopher G. Nelson
Interim Inspector General

August 23, 2023

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 23-BOR-2096

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 Health and Human Resources. 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,

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

Encl: Decision Recourse
Form IG-BR-29
CC: Carrie Casto, [redacted] DHHR

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 23-BOR-2096**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

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 West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on July 19, 2023.

The matter before the Hearing Officer arises from the Respondent's May 26, 2023 decision to terminate the Appellant's Adult Medicaid benefit eligibility.

At the hearing, the Respondent was represented by Carrie Casto, Economic Services Supervisor, [redacted] DHHR. The Appellant appeared and was represented by his attorney, [redacted] Legal Aid of West Virginia. All those present were sworn in and the following documents were admitted into evidence.

Department's Exhibits:
D-1 Medicaid Review Form, submitted May 18, 2023
D-2 West Virginia Income Maintenance Manual (WVIMM) § 3.7
D-3 DHHR eRAPIDS Medicare screen print

Appellant's Exhibits:
A-1 Social Security Administration Benefit Verification Letter, dated July 12, 2023

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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) The Appellant was a recipient of Adult Medicaid benefits.

2) On May 18, 2023, the Appellant submitted his Medicaid review form (Exhibit D-1).

3) On May 26, 2023, the Respondent issued a notice advising the Appellant his eligibility for Medicaid was denied, beginning July 1, 2023, because he is not aged, blind, or disabled.

4) On December 31, 2020, the Appellant became disabled under Social Security Administration rules (Exhibits D-1 and A-1).

5) The reason for the denial was incorrect on the notice.

6) The reason for the Appellant's Adult Medicaid benefit denial was that the Appellant was enrolled in Medicare.

7) The Appellant's Medicare Parts A and B enrollments were effective in June 2023 (Exhibits D-3 and D-4).

8) The Appellant was approved for Specified Low-Income Medicare Beneficiaries (SLIMB) Medicare Premium Assistance effective June 1, 2023 (Exhibit D-3).

APPLICABLE POLICY

Families First Coronavirus Response Act and Fiscal Year (FY) 2023 Omnibus Appropriations Bill provide in relevant sections:

During the COVID-19 PHE, provisions were stipulated permitting the Respondent to provide continuous coverage to Medicaid recipients, regardless of income, during the PHE. On December 23, 2022, Medicaid continuous enrollment was set to end on April 1, 2023.

West Virginia Income Maintenance Manual (WVIMM) § 1.2.2.B *Redetermination Process* provides in relevant sections:

Periodic reviews of total eligibility for recipients are mandated by federal law.

WVIMM §§ 3.7 *Adult Group* through 3.7.1.B *Who Cannot be Included?* provides in relevant sections:

To be eligible for Medicaid Adult Group benefits, individuals must be age 19 or older and under age 65 and cannot be entitled to or enrolled in Medicare Part A or B.

WVIMM § 23.10.4 *Adult Group* provides in relevant sections:

To be eligible for Adult Group Medicaid benefits, the individual may not be entitled to or enrolled in Medicare Part A or B and meet income eligibility requirements described in Chapter 4.

WVIMM §§ 10.6.5.A *Assistance Group* (AG) *Closures* and § 10.6.5.B *Consideration of Eligibility Under Other Coverage* Groups provide in relevant sections:

When the client's circumstances change to the point that he becomes ineligible, the AG is closed. The Department must consider the individual's Medicaid eligibility under other coverage groups before notifying the individual that Medicaid eligibility will end. Advanced notice is required for any adverse action.

WVIMM § 10.8.3 *AG Closures* provides in relevant sections:

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 § 23.12.2 *Specified Low-Income Medicare Beneficiaries (SLIMB)* provides in relevant parts:

Medicaid coverage is limited to the payment of the Medicare Part B premium.

DISCUSSION

Upon a review of the Appellant's Adult Medicaid benefits eligibility, the Respondent determined that the Appellant was ineligible for Adult Medicaid benefits and terminated his eligibility. Pursuant to the notice, the reason for the Appellant's denial was his failure to meet disability criteria. The evidence revealed that the Appellant was disabled. During the hearing, the Respondent's representative testified that the notice should have reflected the Appellant's Medicare enrollment as the basis for the Appellant's Adult Medicaid eligibility termination. The Respondent is required to issue a proper notice advising the Appellant of the correct basis of his Adult Medicaid termination. As the Appellant was granted a hearing on the matter, he was not by the incorrect termination basis reflected on the Respondent's notice.

The Board of Review is required to follow the policy and cannot change the policy or award Adult Medicaid eligibility beyond the circumstances allowed by the policy. The Respondent had to prove by a preponderance of the evidence that the Appellant was not eligible for Adult Medicaid benefits, effective July 1, 2023, because he was enrolled in Medicare benefits. The evidence revealed that the Appellant was enrolled in Medicare benefits, effective June 1, 2023, before the proposed July 1, 2023 date of Adult Medicaid ineligibility. Pursuant to the policy, the Adult Group Assistance Group (AG) is closed the month following the month of the change and

after advance notice for the adverse action. The Appellant completed his review in May 2023. The May 26, 2023 notice reflected July 1, 2023, as the effective date of ineligibility.

During the hearing, the Appellant's representative argued the Appellant should have been evaluated for other Medicaid coverage groups. The policy stipulates that before terminating the Appellant's Adult Medicaid benefits, the Respondent was required to evaluate the Appellant for other Medicaid coverage groups.

Pursuant to the Respondent's representative's testimony and the Medicare Premium Assistance approval notice, the Appellant was evaluated for other Medicaid coverage groups. He was found to be eligible for the SLIMB Medicare Premium Assistance program, effective June 1, 2023. Until the Respondent's witness's testimony was submitted, the Appellant's representative was unaware that the Appellant had been approved for Medicare Premium Assistance. The Appellant's representative did not dispute the Appellant's SLIMB eligibility determination.

CONCLUSIONS OF LAW

1) To be eligible for Adult Medicaid benefits, an individual may not be enrolled in Medicare Part A or B.

2) The preponderance of the evidence demonstrated that the Appellant was enrolled in Medicare Part A and B.

3) The Respondent is required to evaluate the Appellant for other Medicaid coverage groups before terminating his Adult Medicaid benefits.

4) The Appellant was approved for SLIMB Medicare Premium Assistance benefits, effective June 1, 2023.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to terminate the Appellant's Adult Medicaid benefits.

Entered this 23rd day of August 2023.

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Tara B. Thompson, MLS
State Hearing Officer