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

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

Christopher G. Nelson
Interim Inspector General

February 15, 2024

[redacted]

RE: [redacted] v. WVDoHS
ACTION NO.: 24-BOR-1204

[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 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,

Eric L. Phillips
State Hearing Officer
Member, State Board of Review

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

cc: Debra King, BFA

P.O. Box 1736 • Romney, WV 26757
304-822-6900 • https://www.wvdhhr.org/oig/bor.html •
Eric.l.Phillips@wv.gov• OIGBOR@WV.GOV

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 24-BOR-1204**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
BUREAU OF 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 West Virginia Office of Inspector General's Common Chapters Manual. This fair hearing was convened on February 14, 2024, on an appeal filed January 23, 2024.

The matter before the Hearing Officer arises from the January 10, 2024 decision by the Respondent to terminate the Appellant's eligibility for Adult Medicaid assistance.

At the hearing, the Respondent appeared by Debra King, Family Support Supervisor. The Appellant appeared *pro se*. Appearing as a witness for the Appellant was [redacted] All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Decision dated January 10, 2024

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 was a recipient of Adult Medicaid benefits.

2) During the COVID-19 Public Health Emergency (PHE) continuous coverage was provided to all Medicaid recipients, regardless of income.

3) PHE continuous coverage for Medicaid recipients expired on April 1, 2023.

4) In January 2024, the Appellant was required to complete a recertification for Adult Medicaid.

5) The Appellant receives disability benefits from the Social Security Administration (SSA) in the amount of $1789.70.

6) The Appellant receives Medicare assistance and pays a monthly premium of $174.70.

7) On January 10, 2024, the Respondent issued a Notice of Decision to the Appellant citing that he no longer met the eligibility requirements for the Medicaid program. (Exhibit D-1)

APPLICABLE POLICY

West Virginia Income Maintenance Manual §1.2.2. B documents in pertinent 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.

West Virginia Income Maintenance Manual § 3.7.1.A documents in part:

> Adults age 19 or older and under age 65 are included in Adult Medicaid Coverage groups.

West Virginia Income Maintenance Manual § 10.8.3 documents in pertinent part:

> The AG must be closed when the individual(s):
>
> - Turns age 65;
> - Begins receiving Medicare Part A or B; or
> - 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.

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

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

DISCUSSION

The Appellant was a recipient of Adult Medicaid benefits during COVID-19 PHE. During the PHE, provisions were enacted which permitted the Respondent to provide continuous coverage to Medicaid recipients, regardless of their income. The continuous coverage provisions expired on April 1, 2023; and all recipients were subject to eligibility requirements. The Appellant, a recipient of disability benefits through the Social Security Administration, became eligible for Medicare assistance while receiving Adult Medicaid benefits. Upon initial recertification after the PHE expiration, the Respondent discovered the Appellant's receipt of Medicare assistance and terminated his eligibility for Adult Medicaid assistance.

Policy mandates that Medicaid coverage is provided to individuals between the ages of 19 and 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 coverage. Upon expiration of the COVID-19 PHE, which provided continuous Medicaid coverage regardless of income, the Appellant was required to complete a recertification of benefits in January 2024. The Respondent terminated the Appellant's eligibility for Adult Medicaid coverage based his receipt of Medicare assistance. The Respondent must prove by a preponderance of the evidence that the Appellant no longer met the requirements for Adult Medicaid benefits.

The Appellant, who has been determined disabled since 2018, testified that he receives a monthly disability benefit from the SSA in the amount of $1789.70. The Appellant indicated that if he no longer receives Adult Medicaid assistance, ongoing medical expenses, including insurance co-payments and Medicare premiums, will create a financial burden on his household.

Debra King, Family Support Supervisor, informed the Appellant of additional community resources and Departmental programs in which he may be eligible based on a separate application.

The policy is clear that Adult Group Medicaid assistance groups must be closed when an individual begins receiving Medicare coverage. Because the Appellant began receiving Medicare assistance during his certification period, he is no longer eligible for Adult Medicaid benefits. Therefore, the Respondent's decision to terminate the Appellant's Adult Medicaid assistance is affirmed.

CONCLUSIONS OF LAW

1) Medicaid coverage is provided to individuals age 19 or older and under age 65 who are not otherwise eligible for and enrolled in another mandatory Medicaid coverage group, and are not entitled to or enrolled in Medicare Part A or B.

2) The Appellant began receiving Medicare assistance during his Adult Medicaid period of consideration.

3) Due to the Appellant's receipt of Medicare assistance, he no longer meets the eligibility requirements for Adult Medicaid assistance.

DECISION

It is the decision of the State Hearing Officer to **uphold** the decision of the Respondent to terminate the Appellant's Medicaid assistance.

ENTERED this _____ day of February 2024.

_____

Eric L. Phillips
State Hearing Officer