April 18, 2025

[redacted]

RE: [redacted] v. WVDoHS
ACTION NO.: 25-BOR-1614

Dear Ms. [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,

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

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

cc: Hollie Cherry, BFA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-1614**

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 April 10, 2025, on appeal March 12, 2025.

The matter before the Hearing Officer arises from the Respondent's failure to cover eligibility for medical services for 2023.

At the hearing, the Respondent appeared by Hollie Cherry, Economic Service Worker. The Appellant appeared pro se. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Computer printout of Participation Status

Appellant's Exhibits:

A-1 Notice of Decision dated March 28, 2023
A-2 Notice of Decision dated October 5, 2023
A-3 Account Summary from [redacted] Hospital

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 is considered disabled by the Social Security Administration.

2) The Appellant is a Medicare recipient.

3) The Appellant received Specified Low-Income Medicare Beneficiary (SLIMB) benefits through the Respondent in August 2023 and September 2023. (Exhibit D-1)

4) The Appellant received Qualified Medicare Beneficiary (QMB) benefits in October 2023. (Exhibit D-2)

5) The Appellant was diagnosed with COVID-19 in 2023.

6) On August 29, 2023, the Appellant completed a physician's visit with her general physician. (Exhibit A-3)

7) On September 25, 2023, the Appellant visited a walk-in clinic for medical services. (Exhibit A-3)

8) On October 12, 2023, the Appellant visited a walk-in clinic for medical services. (Exhibit A-3)

9) On August 29, 2023, the Appellant incurred $126.50 in total charges with a remaining account balance of $25.30. (Exhibit A-3)

10) On September 25, 2023, the Appellant incurred $177.50 of total charges with a remaining account balance of $35.50. (Exhibit A-3)

11) On October 12, 2023, the Appellant incurred $199.25 of total charges with a remaining account balance of $39.86.

12) The Appellant has a remaining account balance of $100.65. (Exhibit A-3)

APPLICABLE POLICY

West Virginia Income Maintenance Manual § 23.12.1 relating to Qualified Medicare Beneficiaries (QMB):

> Medicaid coverage is limited to payment of the Medicare, Part A and Part B premium amounts and payment of all Medicare co-insurance and deductibles, including those related to nursing facility services. The Buy-In Unit pays the Medicare premium. Refer to Chapter 25 for details.

An individual or couple (spouses) is eligible for this limited Medicaid coverage when all the following conditions are met:

• The individual must be entitled to premium-free in Medicare, Part A and/or enrolled in Medicare Part B. He must be entitled to Medicare in any of the following three ways:

o By being age 64 years and 9 months old or older;

o By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,

o By having end-stage renal disease;

• The individual or spouses must meet the income test detailed in Chapter 4; and,
• The individual or spouses must meet the asset test detailed in Chapter 5.

West Virginia Income Maintenance Manual § 23.12.2 regarding Specified Low-Income Medicare Beneficiaries (SLIMB) documents:

Medicaid coverage is limited to payment of the Medicare Part B premium. An individual or couple (spouses) is eligible for this limited Medicaid coverage when all of the following conditions are met:
• The individual must be enrolled in Medicare, Part A. He must be entitled in any of the following three ways:

o By being age 64 years and 9 months old or older;

o By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,

o By having end-stage renal disease;

• The individual or couple must meet the income test detailed in Chapter 4; and,
• The individual or couple must meet the asset test detailed in Chapter 5.

DISCUSSION

The Appellant requests this administrative appeal as a dispute to a bill of payment for medical services from [redacted] Hospital. The dates in question of the disputed bill were from August 2023 through October 2023. The Appellant contends that she was a Medicaid recipient during the COVID-19 Public Health Emergency and was entitled to full coverage of medical services during the timeframe. The Respondent must prove by a preponderance of the evidence that the Appellant was not enrolled in a Medicaid program which provides payment for medical services.

The Appellant is a disabled individual who receives Medicare services through the Social Security Administration. The Appellant was determined financially eligible for Medicare Premium Assistance (MPA). Testimony from the Respondent revealed that the Appellant was determined eligible for Specified Low-Income Medicare Beneficiary (SLIMB) from August 2023 to September 2023. SLIMB Medicaid coverage is limited to the payment of Medicare Part B premiums. In October 2023, the Appellant's Medicaid coverage changed from SLIMB to Qualified Medicare Beneficiary (QMB) assistance. QMB provides Medicaid coverage that is limited to the payment of the Medicare Part A and Part B premium amounts and payment of all Medicare co-insurance and deductibles.

The Appellant was diagnosed with COVID-19 and sought medical attention on three separate occasions during the months of August through October 2023. Each occasion resulted in a separate medical expense which included August 29, 2023, one from September 25, 2023, and the one from October 12, 2023. The Appellant provided an account summary from [redacted]Hospital (Exhibit A-3) which documents that that Appellant incurred medical charges totaling $503.25 for and after insurance payments and adjustments, a total balance due of $100.65 remains. The Appellant contends that because she had COVID-19 and was a recipient of Medicaid during the Federal declaration of a Public Health Emergency (PHE) she should not be responsible for payment of the incurred services. Specifically, the Appellant notes from Notices of Decisions from March 28, 2023 and October 5, 2023 (Exhibit A-1 and Exhibit A-2) that note the following provision:

> Medicaid benefits must be kept open for most individuals during the COVID-19 Public Health Emergency (PHE), therefore you will continue to receive Medicaid benefits. However, if you were determined to not be eligible during this review, your Medicaid benefits will stop after the COVID-19 PHE ends.

The Respondent provided testimony that Appellant has received MPA, since 2014, but the form of Medicaid the Appellant received would not cover medical expenses the same as "traditional Medicaid".

The Respondent determines financial eligibility of an applicant for Medicaid programs. As a matter of this administrative hearing, the Appellant's eligibility for an MPA is not in question.

The Families First Coronavirus Response Act and Fiscal Year (FY) 2023 Omnibus Appropriations Bill mandated that during the COVID-19 Public Health Emergency provides that all Medicaid recipients, regardless of income, would receive continuous coverage until April 1, 2023. The Appellant's contention that she was a recipient of Medicaid services during the federal declaration of a PHE is moot. The declaration expired in April 2023 and the period of eligibility in question is from August 2023 through October 2023. Additionally, the Appellant received Medicaid coverage with specific limitations. During August 2023 and September 2023, the Appellant was eligible for SLIMB coverage which is limited to the payment of Medicare premiums. Because the Appellant's Medicaid coverage had limited liability of coverage, the Appellant was not entitled to payment of any services other than Medicare premium.

In October 2023, the Appellant was a recipient of QMB Medicaid coverage which provides coverage for premium amount and payment of all Medicare co-insurance and deductibles. Evidence from the Account Summary from [redacted] Hospital (Exhibit A-3) notes that the related expenses from October 2023 totaled $199.25 and included insurance payments in the amount of $277.84 and insurance adjustments totaling $118.44. However, the evidence is inclusive to determine whether Medicare or Medicaid was considered in the payment or adjustment. Because this evidence is inconclusive, it cannot be determined if the Medicaid assistance was evaluated for payment of any co-insurance or deductibles. Therefore, this matter should be remanded to the Respondent for additional evaluation of the October 2023 medical expenses.

CONCLUSIONS OF LAW

1) The Appellant was determined eligible for Medicare Premium Assistance Medicaid coverage due to her receipt of Medicare and her financial eligibility.

2) The Appellant's Medicaid coverage was limited to payment of Medicare Part B premiums for August 2023 and September 2023.

3) The Appellant's Medicaid coverage was limited to payment of Medicare Part A and Part B premiums and payment of all Medicare co-insurance and deductibles for October 2023.

4) The Appellant incurred medical expenses in August 2023 through October 2023.

5) The Appellant was not eligible for coverage of the medical expenses in August 2023 and September 2023.

6) Evidence is inconclusive to determine if the incurred October 2023 medical expenses were considered for Medicaid payment.

DECISION

It is the decision of the State Hearing Officer to REVERSE the decision of the Respondent to not consider the October 2023 medical expenses for consideration of payment.

This matter is REMANDED to the Respondent for further evaluation of the medical expenses incurred in October 2023 for Medicaid payment.

ENTERED this _____ day of April 2025.

_____

Eric L. Phillips
State Hearing Officer