September 2, 2025

[redacted]

RE: [redacted] v. WV DoHS/BFA
ACTION NO.: 25-BOR-2464

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 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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Peter VanKleeck, WV DoHS/BFA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 25-BOR-2464**

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 August 19, 2025.

The matter before the Hearing Officer arises from the April 25, 2025, decision by the Respondent to close the Appellant's Modified Adjusted Gross Income (MAGI) Medicaid, Adult Medicaid category.

At the hearing, the Respondent appeared by Maddison Bierbaum, Economic Services Worker. The Appellant was self-represented. Appearing as a witness for the Respondent was Katrina Mercer, Economic Service Worker Senior. The witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:
- D-1 Summary
- D-2 Email from the Appellant dated April 22, 2025
- D-3 Notice of Adult Medicaid closure, dated April 25, 2025
- D-4 Application for Medicare Buy-In Program (DFA-QSQ-1), scanned on May 5, 2025
- D-5 Notice of Medicare Premium Assistance approval, dated May 30, 2025
- D-6 WV Income Maintenance Manual (IMM), Chapter 4, Appendix A

Appellant's Exhibits:
- A-1 Hearing Summary

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 receiving MAGI Medicaid benefits in the Adult Medicaid category.

2) On April 21, 2025, the Appellant reported to the Respondent that he had become eligible for Medicare assistance. (Exhibit D-2)

3) On April 25, 2025, the Respondent issued the Appellant notification that his Adult Medicaid benefits were closing effective June 1, 2025, citing the reason as "You did not request benefits for the persons listed below. You requested this benefit be closed." (Exhibit D-3)

4) The Appellant did not request that his Adult Medicaid be closed.

5) The Appellant became ineligible for Adult Medicaid when he became eligible for Medicare coverage.

APPLICABLE POLICY

Code of Federal Regulations, **42 CFR §435.119, Coverage for individuals age 19 or older and under age 65 at or below 133 percent Federal Poverty Level:**

(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.

42 CFR 435.123, Individuals eligible as qualified Medicare beneficiaries.

(a) **Basis**. This section implements sections 1902(a)(10)(E)(i) and 1905(p)(1) of the Act.

(b) **Eligibility**. The agency must provide medical assistance to individuals who meet all of the following:

(1) Are entitled to Medicare Part A based on the eligibility requirements set forth in § 406.5(a) or § 406.20(b) of this chapter or who are enrolled in Medicare Part B for coverage of

immunosuppressive drugs based on eligibility requirements described in § 407.55 of this chapter.

(2) Have an income, subject to paragraphs (b)(2)(i) and (ii) of this section, that does not exceed 100 percent of the Federal poverty level.

(i) During a transition month (as defined in paragraph (b)(2)(ii) of this section), any income attributable to a cost of living adjustment in Social Security retirement, survivors, or disability benefits does not count in determining an individual's income.

(ii) A transition month is any month of the year beginning when the cost of living adjustment takes effect, through the month following the month of publication of the revised official poverty level.

(3) Have resources, determined using financial methodologies no more restrictive than SSI, that do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the Consumer Price Index for inflation as defined in section 1905(p)(1)(C) of the Act.

(c) **Scope**. Medical assistance included in paragraph (b) of this section includes all of the following:

(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for Parts A and B premiums and cost sharing, including deductibles and coinsurance, and copays.

(2) For individuals enrolled in Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

42 CFR 435.124, Individuals eligible as specified low-income Medicare beneficiaries.

(a) **Basis**. This section implements sections 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act.

(b) **Eligibility**. The agency must provide medical assistance to individuals who meet the eligibility requirements in § 435.123(b), except that income exceeds 100 percent, but is less than 120 percent of the poverty level.

(c) **Scope**. Medical assistance included in paragraph (b) of this section includes the following:

(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for the Part B premium.

(2) For individuals enrolled under Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only coverage of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

42 CFR 435.125, Individuals eligible as qualifying individuals.

(a) **Basis**. This section implements sections 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) of the Act.

(b) **Eligibility**. The agency must provide medical assistance to individuals who meet the eligibility requirements in § 435.123(b), except that income is at least 120 percent, but is less than 135 percent of the Federal poverty level.

(c) **Scope**. Medical assistance included in paragraph (b) of this section includes the following:

(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for the Part B premium.
(2) For individuals enrolled under Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only payment of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

WM IMM, Chapter 10, §10.8.3, in part, explains that for the Adult Medicaid coverage group, 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. [Emphasis added]

WV IMM, Chapter 23, §23.12.1, Qualified Medicare Beneficiaries (QMB), in part, explains that the income limit is 100% of the Federal Poverty Level (FPL). 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.

WV IMM, Chapter 23, §23.12.2, Specified Low-Income Medicare Beneficiaries (SLIMB), in part, explains that the income limit is 101 – 120% FPL. Medicaid coverage is limited to payment of the Medicare Part B premium.

WV IMM, Chapter 23, §23.12.3, Qualified Individual (QI), in part, explains that the income limit is 121 –135% FPL. Medicaid coverage is limited to payment of the Medicare Part B premium.

WV IMM, Chapter 4, Appendix A, lists income limits for the three categories of Medicare Premium Assistance:

100% FPL for a one-person assistance group: $1,305
120% FPL for a one-person assistance group: $1,565
135% FPL for a one-person assistance group: $1,761

WV IMM, Chapter 10, §10.2.1.B, AG Closures: When a client's circumstances change so that he becomes ineligible, the AG is closed. In some situations, the AG is automatically closed by the eligibility system. However, most AG closures are completed by the Worker. AG closures usually involve failure to continue to meet an eligibility requirement. These are addressed in the program-specific items that follow. The closures described below are related to general requirements, common to all programs.

WV IMM, Chapter 9, §9.3.2.C.3 Medicaid and WVCHIP, in part: The notice must include:

- The specific action being taken;
- The date that the action is effective;
- **The reason for the action**; [Emphasis added]

- The IMM section on which the decision is based; and
- Any other action taken.

The following must be included as appropriate:

- For Closures: The fact that the Medicaid AG is being closed.

DISCUSSION

The Appellant was a recipient of MAGI Medicaid, Adult Medicaid category. On April 21, 2025, the Appellant informed the Respondent that he became eligible for Medicare assistance. Accordingly, on April 25, 2025, the Respondent issued notification to the Appellant of the termination of his Adult Medicaid benefits effective June 1, 2025, citing the reason as "You did not request benefits for the persons listed below. You requested this benefit be closed." Policy requires that when an individual becomes eligible for Medicare Part A or B benefits, MAGI Medicaid (Adult Medicaid) coverage must be closed after proper advance notice.

The Appellant brought this appeal stating that on paper "it looks like DOHS has fulfilled its obligations." The Appellant stated that he brought the appeal to point out "some glaring flaws in the DOHS rhetoric and practices that are not compliant with the charged legal duties." Although the Appellant's testimony was vague as to what DoHS rhetoric and practices or the legal duties to which he was referring, overall, the preponderance of his testimony seemed to be with issues he has with United Healthcare (UHC). The Appellant stated that his issue was what he deemed to be a "breach of contract" by UHC as he contended that it "professes to work with fully covered Medicaid patients to cover bills." The Appellant stated that none of his medical expenses were being covered except for his Medicaid Part B premium cost by the state. It is also noted that the Appellant accused UHC of "insurance fraud on the states dime".

At the onset of the hearing, the parties agreed that the issue on appeal was the termination of the Appellant's MAGI Medicaid (Adult Medicaid) benefits. Thus, the Board of Review must determine whether the Respondent correctly terminated the Appellant's MAGI Medicaid. Issues of "insurance fraud" and/or non-covered unspecified medical expenses is beyond the scope of this hearing.

Although the Appellant's testimony was broad and generalized, the Appellant did contend that he was not given a "timeline" as to when his full Medicaid coverage would end and when his "partial" Medicaid would begin. It is noted that the Appellant is not receiving "partial" Medicaid but instead receiving payment for his Medicare Part B premium cost. With regard to a "timeline" for termination of his Medicaid coverage, the April 25, 2025, notification sent to the Appellant, does explain that his Adult Medicaid coverage would be terminated on June 1, 2025. Additionally, on May 30, 2025, the Respondent issued an approval letter regarding his May 7, 2025 MPA application. The May 30, 2025 notification stated that the Appellant would become eligible for Medicare Part B premium payments as of June 1, 2025, under SLIMB coverage, specifically noting that he would not be receiving a Medicaid card. Thus, the April 25, 2025 notice explained that the Appellant's Adult Medicaid coverage would terminate effective June 1, 2025, and the May 30, 2025 notice explained that he would only be eligible for payment of his Medicare Premium B costs beginning June 1, 2025.

In further reviewing the April 25, 2025 closure notification, it does appear to be incorrect. Policy requires that a proper notice of benefit closure include the specific action being taken, the date that the action is effective, the reason for the action, and the WV Income Maintenance Manual section on which the decision is based. All of these notice requirements were met except for the reason for the action. The closure notice erroneously states that the Appellant requested closure. The evidence presented showed that the Appellant did not request that his Adult Medicaid be closed. Instead, the Appellant only reported he became eligible for Medicare. Because the April 25, 2025 closure notice failed to state the reason for the closure as the Respondent's ineligibility for Adult Medicaid benefits, it failed to comply with the policy.

Whereas the April 25, 2025 notice of Adult Medicaid closure failed to indicate the correct reason for the closure, the Respondent failed to comply with notice requirements. The case must be remanded for restoration of any lost Medicaid benefits until proper closure notice is issued by the Respondent.

CONCLUSIONS OF LAW

1) State and Federal regulations mandate that MAGI Medicaid coverage must be closed when an individual becomes eligible for Medicare Part A or B, after advance notice.

2) On April 21, 2025, the Appellant reported he became eligible for Medicare coverage.

3) The Respondent issued a closure notice to the Appellant on April 25, 2025, stating that the Appellant's Adult Medicaid benefits were closed at the Appellant's request.

4) The Appellant did not request that his Adult Medicaid benefits be closed.

5) Policy requires that Medicaid closure notices include the specific action being taken, the date that the action is effective, the reason for the action, and the WV Income Maintenance Manual section on which the decision is based.

6) The April 25, 2025 notice failed to correctly state the reason for the Appellant's Adult Medicaid closure.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's MAGI Medicaid benefits. The case is **REMANDED** for reinstatement of lost months of Medicaid coverage until proper notice is issued to the Appellant.

ENTERED this 2nd day of September 2025.

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Lori Woodward**,** Certified State Hearing Officer